Calendar No. 427

103D CONGRESS
2D SESSION

S. 2096

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 10 (legislative day, MAY 2), 1994

Mr. DOMENICI introduced the following bill; which was read the first time

MAY 16, 1994

Read the second time and placed on the calendar

A BILL

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; DEFINITIONS.

(a) SHORT TITLE.—This Act may be cited as the "Health Care Reform Act of 1994".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(c) DEFINITIONS.—For purposes of this Act:

(1) AHP.—The term "AHP" means an accountable health plan.

(2) ELIGIBLE EMPLOYEE.—The term "eligible employee" means an individual employed by an employer, and includes the spouse and any dependent of such employee. Such term also includes an employee within the meaning of section 401(c)(1) of the Internal Revenue Code of 1986.

(3) ELIGIBLE INDIVIDUAL.—The term "eligible individual" means an individual who is otherwise not eligible for coverage under—

(A) an employer-sponsored health plan, or

(B) the medicare program under title XVIII of the Social Security Act.

The term "eligible individual" includes the spouse and any dependent of such individual unless such spouse or dependent is not an eligible individual.

(4) ELIGIBLE SMALL EMPLOYER.—The term "eligible small employer" means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 employees on a typical business day. For the purposes of this paragraph, the term "employee" includes a self-employed individual.

(5) HEALTH PLAN.—The term "health plan" (including self-insured plans) means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract and, in States which have distinct licensure requirements, a multiple employer welfare arrangement, but does not include any of the following offered by an insurer—

(A) accident only, dental only, disability only insurance, or long-term care only insurance;

(B) coverage issued as a supplement to liability insurance or Medicare;

(C) workmen's compensation or similar insurance; or

(D) automobile medical-payment insurance.

(6) INSURER.—The term "insurer" means any person that offers a health plan to an eligible small employer or eligible individual.

(7) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

TITLE I—IMPROVING PRIVATE HEALTH INSURANCE

Subtitle A—Federal and State Roles

SEC. 101. FEDERAL REFORM AND STATE IMPLEMENTATION.

(a) CERTIFICATION OF STATE HEALTH REFORM PROGRAMS.—

(1) CERTIFICATION.—The Secretary shall establish by regulation a process by which each State shall submit a health reform program to the Secretary, and the Secretary shall determine and certify whether such State program is consistent with the requirements of section 103.

(2) PERIODIC REVIEW.—The Secretary may, from time-to-time, review a State program after such program has been originally certified to ensure continued compliance with section 103 and may decertify such program based on such review.

SEC. 102. APPLICABLE REGULATORY AUTHORITY FOR HEALTH PLANS.

(a) IN GENERAL.—Except as provided in subsection (b), each State shall ensure that health plans offered to individuals residing in such State meet the requirements of this Act, including sections 111 and 112, as applicable.

(b) EXCEPTIONS.—

(1) ERISA PLANS.—The Secretary of Labor shall ensure that health plans established pursuant to the requirements of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) meet the requirements under section 112 for AHPs.

(2) INADEQUATE STATE PLANS.—The Secretary shall ensure that health plans in a State meet the requirements of sections 111 and 112, as applicable, if the Secretary does not certify the health reform program submitted by such State or if the Secretary decertifies the State's program.

(c) EFFECTIVE DATE.—The requirements of this title shall apply to health plans offered, issued, or renewed on or after the later of—

(1) January 1, 1996; or

(2) in the case of a State which the Secretary identifies as requiring State legislation in order to implement this title, the first day of the first calendar quarter beginning after the close of the first regular legislative session of the State legislature that begins after enactment of this Act, but not before January 1, 1996.

For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a regular legislative session of the State legislature.

SEC. 103. STATE HEALTH REFORM PROGRAM REQUIREMENTS.

(a) IN GENERAL.—To be certified by the Secretary as meeting the requirements of this section, a State health reform program must include the following requirements, in addition to any other requirements established by the Secretary by regulation for carrying out this Act:

(1) HEALTH PLAN MARKET AREAS.—A State shall establish health plan market areas, ensuring that—

(A) every resident resides within 1 such market area based on place of residence;

(B) market areas do not overlap;

(C) a metropolitan statistical area is not included in more than 1 such market area; and

(D) the maximum number of State residents have the opportunity to select from competing health plans and AHPs that are likely to be available in such market areas.

(2) INTERSTATE COORDINATION.—A State shall coordinate its health reform program with the programs of bordering and nearby States so that—

(A) 1 health plan market area covers a metropolitan statistical area which crosses State borders; and

(B) residents of a State may have access to providers of health care services of bordering or nearby States.

(3) HEALTH PLAN REGULATION.—A State shall ensure that certified health plans and AHPs offered to residents of the State (other than those plans regulated by the Secretary of Labor under section 102(b)(1)) meet the requirements of section 111 and 112, respectively.

(4) NO BENEFIT MANDATES, ANTIMANAGED CARE REQUIREMENTS.—A State shall ensure that AHPs are not—

(A) required to cover any service in the standard benefits package not otherwise required by the Secretary under section 113;

(B) prohibited or limited from including financial incentives for enrollees to use the services of participating providers;

(C) prohibited or limited from restricting coverage of services to those—

(i) provided by a participating provider; or

(ii) authorized by a designated participating provider;

(D) restricted in the amount of payment made to participating providers for services provided to enrollees or restricted in the ability of such AHPs to pay participating providers for services provided to enrollees on a per-enrollee basis;

(E) prohibited or limited from restricting the location, number, type, or professional qualifications of participating providers;

(F) prohibited or limited from requiring that services be authorized by a primary care physician selected by the enrollee from a list of available participating providers;

(G) prohibited or limited in the use of utilization review procedures or criteria;

(H) required to make public utilization review procedures or criteria;

(I) prohibited or limited from determining the location or hours of operation of a utilization review, provided that emergency services furnished during the hours in which the utilization review program is not open are not subject to utilization review;

(J) required to pay providers for the expenses associated with responding to requests for information needed to conduct utilization review;

(K) restricted in the amount of payment made for the conduct of utilization review;

(L) restricted in the access to medical information or personnel required to conduct utilization review;

(M) required to define utilization review as the practice of medicine or another health care profession; or

(N) required to ensure that utilization review be conducted—

(i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or

(ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(5) SMALL BUSINESS PURCHASING POOL.—

(A) IN GENERAL.—A State shall ensure that small group purchasing pools meet the requirements of section 121.

(B) STATE-SPONSORED POOLS.—If, any market area established by the State (or market area that is within the borders of more than 1 State) does not have a small group purchasing group in operation that meets the requirements of section 121, the State shall sponsor such a pool meeting the requirements of section 121.

(6) HEALTH DISCOUNT PROGRAM.—A State shall establish a health discount program meeting the requirements of part I of subtitle B of title III.

(7) MEDICAL LIABILITY REFORM.—A State shall ensure that medical liability laws in the State meet the requirements of subtitle A of title V.

(b) STATE FLEXIBILITY.—

(1) IN GENERAL.—The Secretary shall ensure that State health reform programs are consistent with—

(A) a nationwide private health insurance system;

(B) cost control based on cost-conscious consumers and fair competition among competing health plans based on the cost and quality of such plans; and

(C) freedom for residents to choose and pay for health care providers and health insurance as such residents wish.

(2) FLEXIBILITY.—The Secretary may allow States to propose alterations to the framework of this Act if such alterations are consistent with paragraph (1), do not increase the Federal budget deficit in any year, and—

(A) the State had enacted a State health reform program prior to enactment of this Act that supercedes provisions of this Act; or

(B) the State can demonstrate that provisions of this Act do not provide sufficient access to health care services for residents of a portion of the State (particularly in underserved rural areas) and alterations to the State health reform program will improve access without jeopardizing the quality of health care and without undue State regulation of health care providers.

(3) NO SINGLE PAYER PLANS.—The Secretary may not certify any State health reform program which proposes to create a single payer health insurance plan in any portion of the State.

(c) ENFORCEMENT.—If a State does not have a certified State health reform program, Federal spending for health discounts in the State under title III shall be limited to the level of Federal spending that would have occurred in such State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) if this Act had not been enacted.

Subtitle B—Health Plan Requirements

SEC. 111. CERTIFIED HEALTH PLAN REQUIREMENTS.

(a) IN GENERAL.—To be certified as meeting the requirements of this section, a health plan shall meet the requirements of the following subsections.

(b) LIMITATION IN PREEXISTING CONDITION CLAUSES.—

(1) IN GENERAL.—To be certified as meeting the requirements of this subsection, a health plan may, subject to the succeeding provisions of this subsection, exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A health plan shall provide that if an individual under such plan is in a period of continuous coverage (as defined in subparagraph (B)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by

1 month for each month in the period of continuous coverage.

(B) PERIOD OF CONTINUOUS COVERAGE.—For purposes of this paragraph, the term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under a health plan, titles XVIII or XIX of the Social Security Act, or other health benefits arrangement which provides benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(3) PREEXISTING CONDITION.—For purposes of this subsection, the term "preexisting condition" means, with respect to coverage under a health plan issued, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(c) SMALL GROUP MARKET REFORM.—To be certified as meeting the requirements of this subsection, a health plan shall meet the following:

(1) GUARANTEED ELIGIBILITY.—

(A) IN GENERAL.—No health plan may exclude from coverage—

(i) any eligible individual who does not qualify for assistance under section 311, or

(ii) any eligible employee to whom coverage is made available by an eligible small employer.

(B) WAITING PERIODS.—Subparagraph (A)(ii) shall not apply to any period an eligible employee is excluded from coverage under the health plan solely by reason of a requirement applicable to all employees that a minimum period of service with the eligible small employer is required before the employee is eligible for such coverage.

(2) GUARANTEED AVAILABILITY.—

(A) IN GENERAL.—A health plan offered to any eligible small employer or eligible individual in a health plan market area shall be made available to all eligible small employers and eligible individuals in the health plan market area.

(B) STATE OPTION.—To ensure availability, each State may require all health plans offered to eligible small employers or eligible indi-

viduals in a health plan market area be made available through small group purchasing pools, and that such pools be open to all eligible small employers and eligible individuals.

(3) GUARANTEED RENEWABILITY.—

(A) IN GENERAL.—A health plan issued to an eligible small employer or eligible individual shall be renewed, at the option of the eligible small employer or eligible individual, unless the plan is terminated for a reason specified in subparagraph (B) or (C).

(B) TERMINATION OF SMALL EMPLOYER OR INDIVIDUAL BUSINESS.—An insurer is not required to renew a health plan with respect to an eligible small employer or such an eligible individual, as the case may be, if the insurer—

(i) elects not to renew all of its health plans issued to eligible small employers or eligible individuals, as the case may be, in a health plan market area; and

(ii) provides notice to the applicable regulatory authority in the State and to each eligible small employer or eligible individual covered under a plan of such ter-

mination at least 180 days before the date of expiration of the plan.

In the case of such a termination, the insurer may not provide for issuance of any health insurance plan to an eligible small employer or eligible individual, as the case may be, in the State during the 5-year period beginning on the date of termination of the last plan not so renewed.

(C) GROUNDS FOR REFUSAL TO RENEW.—

(i) IN GENERAL.—An insurer may refuse to renew, or may terminate, a health plan only for—

(I) nonpayment of premiums,

(II) fraud or misrepresentation, or

(III) failure to maintain minimum participation rates (consistent with clause (ii).

(ii) MINIMUM PARTICIPATION RATES.—An insurer may require, with respect to a health plan issued to an eligible small employer, that a minimum percentage of eligible employees who do not otherwise have health plan coverage are enrolled

in such plan if such percentage is applied uniformly to all plans offered to employers of comparable size.

(4) PREMIUMS.—

(A) LIMITATION ON PREMIUM VARIATION.—

(i) IN GENERAL.—The premium charged by an insurer for each type of benefits package offered as a certified health plan to any eligible employee or eligible individual in a health plan market area within a class of family enrollment and age band may not exceed the premium charged for the same benefits package offered to any other eligible employee or eligible individual by more than 20 percent.

(ii) ENROLLMENT CLASS.—For purposes of this subparagraph, the classes of family enrollment are—

(I) individual;

(II) couple;

(III) individual with children; and

(IV) couple with children.

(iii) AGE BANDS.—The Secretary shall establish appropriate age bands with respect to principal enrollees for determining the compliance with this subparagraph.

(B) RISK ADJUSTMENTS.—

(i) IN GENERAL.—Premiums paid to health plans offered in the small group market in a health plan market area shall be adjusted to reflect the relative risk of enrollees in such plan compared to all eligible employees and eligible individuals in the health plan market area.

(ii) MODEL PROGRAMS.—The Secretary shall establish model risk adjustment programs that States may adopt to ensure compliance with clause (i).

(d) PARITY COVERAGE OF SEVERE MENTAL ILLNESSES.—

(1) IN GENERAL.—To be certified as meeting the requirements of this subsection, a health plan shall provide parity coverage for all severe mental illnesses (as defined in regulations by the Secretary), including parity cost-sharing for services necessary to treat such illnesses.

(2) DEFINITION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of paragraph (1), the Secretary shall define severe mental illness through diagnosis, disability, and duration, and include in such definition the following disorders with psychotic symptoms:

(i) Schizophrenia.

(ii) Schizoaffective disorder.

(iii) Manic depressive disorder.

(iv) Autism.

(v) Severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.

(B) CHILDREN.—For purposes of paragraph (1), the Secretary shall define severe mental illness for individuals under age 22 to also include—

(i) psychotic disorders;

(ii) attention deficit hyperactivity disorder;

(iii) autism and pervasive development disorder;

(iv) severe childhood eating disorders;

(v) Tourette's syndrome; and

(vi) any behavioral disorder that would result in conduct which may place the individual or another individual in danger of death or serious bodily injury.

(3) DIAGNOSIS.—For purposes of paragraph (1), services necessary to properly diagnose an individual's mental health disorder shall be considered services necessary to treat a severe mental illness.

SEC. 112. ADDITIONAL REQUIREMENTS FOR ACCOUNTABLE HEALTH PLANS.

(a) CERTIFICATION.—To be certified as an AHP, a health plan must meet the requirements of the following subsections of this section in addition to the requirements of section 111.

(b) GENERAL REQUIREMENTS.—A health plan shall—

(1) provide all medically necessary and effective health benefits (as covered by the benefits package specified in an AHP contract) for a fixed premium for each enrollee for a specified period of time; and

(2) collect and report to the plan's enrollees and the general public objective measures of the quality of the plan's health care, the impact of the plan's health care on the health status of enrollees, and en-

rollee satisfaction with the plan's cost, quality, and service.

(c) CAPACITY LIMITS AND NONDISCRIMINATION.—

(1) IN GENERAL.—A health plan may apply to the applicable regulatory authority to impose a limit on enrollment if enrollment beyond the limit is—

(A) not discriminatory and is based on a "first-come, first-served" enrollment policy, and

(B) is necessary to ensure quality of care for enrollees.

(2) PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS.—A health plan may not deny, limit, or condition the coverage under (or benefits of) the plan based on the health status of the individual, claims experience of an individual, receipt of health care by an individual, receipt of public subsidies by an individual, lack of evidence of insurability of an individual, or any other characteristic of an individual that may relate to the utilization of health care services.

(3) SERVICE AREAS.—A health plan may not discriminate in the drawing of service area boundaries on the basis of race, ethnicity, socio-economic status, age, or anticipated need for health services.

(d) ADJUSTED COMMUNITY RATING IN THE SMALL GROUP MARKET.—

(1) IN GENERAL.—A health plan shall charge a standard premium for each type of benefits package offered to eligible employees of eligible small employers and eligible individuals in a health plan market area, but may elect to adjust the premium for the class of family enrollment and the age of the principal enrollee.

(2) EXEMPTION FOR SMALL GROUP PURCHASING POOLS.—The standard premium charged for a health plan offered to eligible employees of eligible small employers and eligible individuals through a small group purchasing pool may be lower than the premium required pursuant to paragraph (1) if at least 30 percent of all health plan premiums paid in the small group market in the health plan market area are made through such a pool.

(3) ENROLLMENT CLASS.—For purposes of this subsection, the classes of family enrollment are—

(A) individual;

(B) couple;

(C) individual with children; and

(D) couple with children.

(4) AGE BANDS.—The Secretary may establish appropriate age bands with respect to principal enrollees for determining the compliance with this subsection.

(e) QUALITY ASSURANCE.—

(1) INTERNAL QUALITY ASSURANCE AND QUALITY IMPROVEMENT PROGRAM.—A health plan offering covered services that must or may be obtained from participating providers must administer an internal quality assurance and quality improvement program that—

(A) meets the following criteria:

(i) Is clearly identified and fully explained to all participants in the program.

(ii) Is coordinated with other medical management activities.

(iii) Communicates findings to providers and consumers with the primary goal of improving care outcomes.

(iv) Measures the impact of such findings on the care delivered by providers.

(v) Documents the monitoring and evaluation of the quality of care to identify areas for improvement.

(vi) Develops and implements explicit strategies to improve care.

(vii) Collects and analyzes data to facilitate evaluation of improvement strategies.

(viii) Measures the effect of such strategies on care outcomes and the quality of care.

(ix) Incorporates a credentialing process that encompasses initial credentialing, recredentialing, recertifying or reappointment of providers, or both.

(x) Is accountable directly to the governing body of the AHP or, in instances in which the governing body's participation in quality assurance is not direct, to a designated committee of senior management; or

(B) is accredited by an independent organization, such as the National Committee for Quality Assurance, that conducts objective quality reviews based upon comparable criteria.

(2) MEASURING AND COMPARING QUALITY.—

(A) IN GENERAL.—A health plan shall comply with a process, established by the Sec-

retary by regulation, by which such plan shall provide to the appropriate regulatory authority (in an electronic form) standardized information necessary to—

(i) objectively measure and evaluate the performance of such plan;

(ii) fairly compare the performance of such plan with other AHPs; and

(iii) assess the health status of enrollees in such plan to allow fair risk adjustments among competing AHPs.

(B) REQUIRED DATA.—The Secretary shall establish by regulation the necessary information such plan must provide, including—

(i) quality measures, especially measures of health outcomes, including the clinical health, functional status, and well being of enrollees before and after treatments and other services provided by the plan;

(ii) measures of patient access and satisfaction;

(iii) membership and utilization information;

(iv) financial information;

(v) health plan management activities information; and

(vi) any other information determined to be necessary by the Secretary for ensuring fair competition among AHPs based on cost and quality.

(C) USE OF DATA.—

(i) IN GENERAL.—The Secretary shall establish by regulation a process by which such standardized information may be distributed by the appropriate regulatory authority in a manner that promotes accountability to AHP enrollees and fair competition among AHPs based on cost and quality.

(ii) WIDE ACCESS.—The Secretary shall ensure that small business purchasing pools and State health discount programs have access to such information to ensure fair competition among AHPs in those such pools and health discount programs.

(iii) PATIENT CONFIDENTIALITY.—The Secretary shall ensure by regulation that the confidentiality of medical records of individual enrollees is protected.

(f) MARKET CONDUCT REQUIREMENTS.—

(1) REQUIRED WRITTEN MATERIALS.—A health plan shall provide written descriptions of the plan's—

(A) covered benefits, services, and procedures that clearly and fully describe any and all limitations of coverage, use of participating providers and other limits on enrollees' use of services; and

(B) out-of-pocket costs, including copayments, deductibles, coinsurance, and established aggregate maximums on out-of-pocket costs.

(2) ADVERTISING.—All health plan advertising, promotional materials, and other communications with enrollees of the public must be factually accurate and understandable to diverse populations.

(g) ENROLLEE GRIEVANCES.—A health plan shall maintain procedures for hearing and resolving grievances between the plan (and any entity or individual through which the plan provides health care services) and the enrollees.

(h) POINT OF SERVICE PLAN.—A health plan offering covered services that must be obtained from participating providers shall make available an alternative insurance

plan that provides for a point of service option under which an enrollee may select any licensed health care provider to obtain services and such a plan shall pay such provider not less than 50 percent of the cost of such provider's services. A health plan may charge a higher premium for such an alternative insurance plan.

(i) FINANCIAL SOLVENCY.—

(1) IN GENERAL.—A health plan shall be required to demonstrate evidence of adequate capitalization and other indicators of fiscal health, including—

(A) total assets greater than total unsubordinated liabilities;

(B) sufficient cash flow and adequate liquidity to meet obligations as such obligations become due;

(C) an insolvency protection plan; and

(D) insurance or other acceptable arrangements to protect the health plan against liability and casualty risks, including professional liability.

(2) INSOLVENCY.—

(A) Enrollees in the health plan shall be held harmless from incurring liability for any

fees that are the legal obligation of an insolvent plan.

(B) A health plan offering coverage in a market area in which an AHP has become insolvent shall be required to accept enrollment of enrollees of such insolvent AHP, subject to capacity limits.

(j) MEDICAL LIABILITY REFORM.—A health plan shall comply with requirements established pursuant to section 501(d).

(k) ADMINISTRATIVE COST REDUCTION.—A health plan shall comply with the requirements established pursuant to subtitle C of title V.

(l) PARTICIPATION IN HEALTH DISCOUNT PROGRAMS.—Except for health plans established pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), a health plan shall comply with the requirements established by the State in accordance with subtitle B of title III for making AHPs available to individuals eligible for health discounts.

SEC. 113. STANDARD BENEFITS.

(a) STANDARD BENEFITS PACKAGE.—The Secretary shall promulgate regulations establishing a standard benefits package meeting the following requirements:

(1) COVERAGE.—The standard benefits package shall cover—

(A) inpatient and outpatient hospital services;

(B) physician services;

(C) diagnostic services and tests;

(D) outpatient prescription drugs;

(E) preventive services; and

(F) such other services as determined necessary and appropriate by the Secretary.

(2) PARITY COVERAGE OF SEVERE MENTAL ILLNESSES.—The standard benefits package shall be consistent with the requirement for parity coverage of severe mental illnesses, pursuant to section 111(d).

(3) COST SHARING.—The Secretary shall establish for the standard benefits package—

(A) a cost-sharing arrangement consistent with health care delivered by health maintenance organizations, including an annual limit on an enrollee's out-of-pocket expenses (excluding an enrollee's expenses for services provided under an AHP point of service option);

(B) a cost-sharing arrangement consistent with health care covered by fee-for-service

health insurance which is actuarially equivalent to the arrangement established under subparagraph (A); and

(C) any other actuarially equivalent cost-sharing arrangements consistent with other health care delivery systems.

(b) NOMINAL COST-SHARING BENEFITS PACKAGE.—For each cost-sharing arrangement established under subsection (a)(3), the Secretary shall also establish a nominal cost-sharing benefits package for purposes of determining health discounts for poor eligible individuals and poor eligible employees under part I of subtitle B of title III. Such benefits packages shall cover the same services as the standard benefits package but with cost-sharing requirements that are not excessive for such individuals and employees.

(c) ALTERNATIVE BENEFITS PACKAGE.—For each cost-sharing arrangement established under subsection (a)(3), the Secretary shall also establish an alternative benefits package that may be necessary for determining health discounts for low income eligible individuals and low income eligible employees under part I of subtitle B of title III. Such alternative benefits packages shall cover the same services as the standard benefits package but with cost-sharing requirements that are sufficient to de-

crease the average actuarial value of the standard benefits package by 50 percent.

Subtitle C—Improved Health Plan Delivery

SEC. 121. SMALL GROUP PURCHASING POOLS.

(a) IN GENERAL.—Each small group purchasing pool in a health plan market area in a State shall provide a process for eligible employees of eligible small employers and eligible individuals who are not entitled to health discounts under part I of subtitle B of title III to have the opportunity to select annually from among competing AHPs offering the standard benefits package (and, for poor eligible employees, the nominal cost-sharing benefits package) at an adjusted community rate for the coverage period.

(b) REQUIREMENTS.—Each small group purchasing pool shall—

(1) be established as a private, not-for-profit corporation serving eligible small employers and eligible individuals in a health plan market area;

(2) contract with eligible small employers and eligible individuals to provide services for a defined period for a fixed administrative fee per coverage period;

(3) be governed by a board of directors elected by members of the pool;

(4) contract only with AHPs capable of providing coverage to the members of the pool throughout the health plan market area;

(5) require all AHPs to offer at least the standard benefits package and any other package of benefits as specified by the pool, and, if an AHP offers covered services that must be obtained from participating providers, the alternative point of service insurance plan for such AHP;

(6) provide information to members concerning the cost and quality of the competing AHPs offered through the pool; and

(7) offer to provide administrative services to members for the collection of premiums to be forwarded to AHPs.

(c) PROHIBITIONS.—Small group purchasing groups may not—

(1) decline to contract with an AHP if the insurer seeks to offer to members of the pool and the plan meets the requirements of subsection (b);

(2) decline membership to any eligible small employer or eligible individual located in the health plan market area;

(3) negotiate AHP premiums on behalf of members; or

(4) negotiate payment rates for health care providers contracting with AHPs offered through the pool.

SEC. 122. EMPLOYER RESPONSIBILITY.

(a) AHP AVAILABILITY.—

(1) IN GENERAL.—Each employer shall—

(A) offer to each eligible employee enrollment in an AHP providing a standard benefits package that serves the area in which the employee resides, both on an individual basis, and, if applicable and at the employee's option, on a family basis, and, if an AHP offers covered services that must be obtained from participating providers, the alternative point of service insurance plan for such AHP;

(B) provide, at the option of the employee, for deduction from wages or other compensation of amount of any premiums due for such enrollment (taking into account the amount of any employer contribution); and

(C) if such employer is an eligible small employer, also make available an AHP providing the nominal cost-sharing benefits package.

Nothing in this paragraph shall be construed as preventing an employer from offering, or an employee from electing enrollment in, an AHP that serves the area in which the employee is employed, rather than the area in which the employee resides.

(2) SMALL EMPLOYERS.—Each eligible small employer may comply with the requirements of this subsection by participating in a small group purchasing pool.

(b) ENFORCEMENT.—

(1) CIVIL MONEY PENALTIES FOR FAILURE TO OFFER COVERAGE OR PROVIDE FOR WAGE DEDUCTION.—Failure to offer coverage or provide for deduction from wages required under subsection (a)(1) is subject to a civil monetary penalty (not to exceed $500) for each day in which the violation continues.

(2) DIRECT ENFORCEMENT.—The obligation to offer coverage under subsection (a) with respect to an eligible employee is directly enforceable by civil action by the employee. In any such action, if the employee substantially prevails, the employee is entitled to reasonable attorneys' fees.

TITLE II—TAX AND ENFORCEMENT PROVISIONS

SEC. 200. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—General Tax Provisions

SEC. 201. CERTAIN EMPLOYER HEALTH PLAN CONTRIBUTIONS INCLUDED IN INCOME.

(a) EXCLUSION FOR EMPLOYER HEALTH PLAN CONTRIBUTIONS LIMITED TO CONTRIBUTIONS TO ACCOUNTABLE HEALTH PLANS OR CERTIFIED HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"SEC. 106. CONTRIBUTIONS BY EMPLOYER TO HEALTH PLANS.

"Except as provided in section 91, gross income of an employee does not include employer-provided coverage under an accountable health plan (within the meaning of section 112 of the Health Care Reform Act of 1994) or

employer-provided coverage under a certified health plan (within the meaning of section 111 of such Act)".

(2) CLERICAL AMENDMENT.—The table of sections of part III of subchapter B of chapter 1 is amended by striking the item relating to section 106 and inserting the following new item:

"Sec. 106. Contributions by employer to health plans.".

(b) INCLUSION IN INCOME.—

(1) IN GENERAL.—Part II of subchapter B of chapter 1 (relating to items specifically included in gross income) is amended by adding at the end the following new section:

"SEC. 91. EXCESS EMPLOYER CONTRIBUTIONS TO HEALTH PLANS.

"(a) GENERAL RULE.—Notwithstanding section 106, if—

"(1) an employee is covered by an accountable health plan or a certified health plan at any time during any month, and

"(2) there is an excess employer contribution with respect to the employee to such plan for such month,

the gross income of such employee for the taxable year which includes such month shall include an amount equal to such excess employer contribution for such month.

"(b) EXCESS EMPLOYER CONTRIBUTION DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'excess employer contribution' means, with respect to an employee enrolled in an accountable health plan or a certified health plan for any month, the excess of—

"(A) the employer contribution to such plan for such month, over

"(B) the applicable percentage of the applicable dollar limit for such employee for such month.

"(2) APPLICABLE DOLLAR LIMIT.—

"(A) IN GENERAL.—For purposes of paragraph (1) and except as provided in subparagraph (B), the applicable dollar limit for an employee for any month is equal to—

"(i) in the case of individual coverage, $340,

"(ii) in the case of couple coverage, $690,

"(iii) in the case of individual with dependent child or children coverage, $670, and

"(iv) in the case of couple with dependent child or children, .$910.

For any calendar year beginning after 2000, the dollar amounts specified in this paragraph for such year shall equal the dollar amounts under this paragraph for the previous calendar year increased by the percentage increase in the per capita Gross Domestic Product for the previous calendar year.

"(B) REDUCTION OF APPLICABLE DOLLAR LIMIT.—

"(i) IN GENERAL.—Each dollar amount contained in clauses (i), (ii), (iii), and (iv) of subparagraph (A) for the calendar year shall be reduced (but not below 50 percent of such dollar amount) by the amount determined under clause (ii).

"(ii) AMOUNT OF REDUCTION.—The amount determined under this clause with respect to any dollar amount shall be the amount which bears the same ratio to 50 percent of such dollar amount as the excess of—

"(I) the taxpayer's adjusted gross income (determined without re-

gard to this section) for the taxable year ending in the calendar year, over

"(II) the applicable income amount,

bears to $25,000.

"(iii) APPLICABLE INCOME AMOUNT.—For purposes of clause (ii)(II), the term 'applicable income amount' means $75,000 ($50,000, in the case of a taxpayer described in section 1(c)).

"(3) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage for any taxable year—

"(A) in the case of an accountable health plan, is 100 percent, and

"(B) in the case of a certified health plan, is 100 percent reduced by 20 percentage points (but not below zero percent) for each taxable year beginning after December 31, 1996.

"(c) SPECIAL RULE FOR MULTIEMPLOYER HEALTH PLANS.—In the case of employer contributions with respect to any employee made to a multiemployer health plan on a basis other than per employee per month, the Secretary may by regulations prescribe the method of de-

termining that portion of such contributions that is not included in gross income of the employee.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) ACCOUNTABLE OR CERTIFIED HEALTH PLAN.—The terms 'accountable health plan' and 'certified health plan' have the meanings given to such terms by section 106.

"(2) EMPLOYEE INCLUDES FORMER EMPLOYEE.—The term 'employee' includes a former employee.

"(3) DETERMINATION OF EMPLOYER CONTRIBUTION.—

"(A) IN GENERAL.—The employer contribution to any accountable health plan or certified health plan for any month shall be that portion of the cost of such plan for such month which is incurred by the employer.

"(B) SELF-INSURED PLAN MAY USE ANNUAL ESTIMATES.—An employer who maintains a self-insured health plan may elect (in such manner and at such time as may be provided in regulations) to determine the actual employer contribution under subsection (b)(1)(A) for any period of not more than 12 months on the basis

of a reasonable estimate of the cost of providing coverage for such month. To the extent practicable, such estimate shall be made on an actuarial basis, and in the making of any such estimate, there shall be taken into account such factors as may be required under regulations.

"(C) EMPLOYEES ONLY TAKEN INTO ACCOUNT FOR PERIODS COVERED.—For purposes of determining the employer contribution, amounts shall be taken into account with respect to an employee only for periods during which such employee is covered by the plan.

"(4) COVERAGE FOR ONLY PART OF MONTH.—If an employee is covered under an accountable health plan or certified health plan for only a portion of a month, the amount required to be included under subsection (a) in the gross income of such employee with respect to such month shall be an amount which bears the same ratio to the excess employer contribution for such month as such portion bears to the entire month.

"(5) CERTAIN RELATED EMPLOYERS TREATED AS 1 EMPLOYER.—Rules similar to the rules provided by subsections (b) and (c) of section 414 shall apply.

"(6) MONTH.—The term 'month' means a calendar month.

"(7) MULTIEMPLOYER HEALTH PLAN.—The term 'multiemployer health plan' means an accountable health plan which is part of an employee welfare benefit plan (within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974)—

"(A) to which more than 1 employer is required to contribute, and

"(B) which is maintained pursuant to 1 or more collective bargaining agreements between 1 or more employee organizations and more than 1 employer.".

(2) CLERICAL AMENDMENT.—The table of sections for part II of subchapter B of chapter 1 is amended by adding at the end the following:

"Sec. 91. Excess employer contributions to health plans.".

(c) EMPLOYMENT TAX AMENDMENTS.—

(1) GENERAL RULE.—Chapter 25 (relating to general provisions relating to employment taxes) is amended by adding at the end the following new section:

"SEC. 3510. TREATMENT OF EXCESS EMPLOYER CONTRIBUTIONS.

"(a) IN GENERAL.—For purposes of this subtitle and section 209 of the Social Security Act, any amount required to be included in the gross income of an employee under section 91(a) with respect to any month—

"(1) shall be treated as paid in cash to such employee at the close of such month, and

"(2) shall not be treated as paid under a health or similar plan of the employer.

For purposes of paragraph (1), an employer may elect to prorate any such amount to any payroll period (or portion thereof) covering such month rather than treat it as being paid at the close of such month.

"(b) SPECIAL RULES IN THE CASE OF SELF-INSURED PLANS.—

"(1) SAFE HARBOR FOR EMPLOYEES WHOSE ESTIMATES ARE AT LEAST 95 PERCENT OF ACTUAL EMPLOYER CONTRIBUTIONS.—In the case of an employer who maintains a self-insured health plan, if for any calendar year the excess of—

"(A) the actual employer contributions determined under section 91 with respect to all employees for such year, over

"(B) the amount estimated by the employer under section 91(d)(3)(B) as the em-

ployer contributions with respect to all employees for such year,

is not greater than 5 percent of the amount determined under subparagraph (A) then, except as provided in paragraph (2), no penalty shall be imposed under section 6672 on the employer for failure to pay, or to deduct and withhold, any tax imposed by this subtitle on such excess.

"(2) EMPLOYER MUST PAY CERTAIN TAXES ON EXCESS.—Paragraph (1) shall not apply to any tax imposed, or required to be deducted and withheld, under sections 3111, 3221, 3301, and 3402 on the excess described in paragraph (1) unless the employer pays any such tax within the time prescribed by the Secretary under regulations.

"(3) SPECIAL RULES FOR EMPLOYEE'S SOCIAL SECURITY TAX AND CREDIT.—In the case of the excess described in paragraph (1)—

"(A) no tax shall be imposed by section 3101, and

"(B) the amount of such excess shall not be taken into account for purposes of section 209 of the Social Security Act.

"(c) LIABILITY FOR WITHHOLDING AND PAYMENT OF TAX.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the applicable payer shall withhold, and be liable for, payment of any tax required to be withheld or paid under this subtitle on any amount described in subsection (a).

"(2) SPECIAL RULES FOR MULTIEMPLOYER HEALTH PLANS.—In the case of any multiemployer health plan, the plan administrator shall comply with such rules with respect to the withholding of, and liability for, any tax required to be withheld or paid under this subtitle as the Secretary may require by regulations.

"(d) DEFINITIONS.—For purposes of this section—

"(1) APPLICABLE PAYER.—The term 'applicable payer' means the payer of remuneration for services which qualifies the employee for coverage under a multiemployer health plan.

"(2) EMPLOYEE.—The term 'employee' does not include a former employee.

"(3) MULTIEMPLOYER HEALTH PLAN.—The term 'multiemployer health plan' has the meaning given such term by section 91(d)(7).".

(2) CLERICAL AMENDMENT.—The table of sections for chapter 25 is amended by adding at the end the following new item:

"Sec. 3510. Treatment of excess employer contributions.".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to taxable years beginning after December 31, 1995.

(2) EMPLOYMENT TAX.—The amendments made by subsection (c) shall take effect on and after January 1, 1996.

SEC. 202. DEDUCTIONS FOR COSTS OF HEALTH PLANS.

(a) BUSINESS EXPENSE DEDUCTION FOR HEALTH INSURANCE.—Section 162 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

"(m) GROUP HEALTH PLANS.—The amount of expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section—

"(1) unless the plan is an accountable health plan or certified health plan (as defined in section 106),

"(2) unless such employer does not vary the amount incurred among plans offered to each employee (other than with respect to the benefits package and family class of enrollment coverage), and

"(3) with respect to each employee, to the extent such amount exceeds the applicable dollar limit for such employee (within the meaning of section 91(b)(2) (without regard to subparagraph (B) thereof) and determined on an annual basis).".

(b) PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.—

(1) PERMANENT EXTENSION OF DEDUCTION.—

(A) IN GENERAL.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 1993.

(2) INCREASE IN AMOUNT OF DEDUCTION; INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

(A) INCREASE IN AMOUNT OF DEDUCTION.—Paragraph (1) of section 162(l) is amended—

(i) by striking "25 percent of" and inserting "100 percent of", and

(ii) by striking "dependents." and inserting "dependents, and only to the extent such amount does not exceed the applicable dollar limit for such taxpayer (within the meaning of section 91(b)(2) and determined on an annual basis)."

(B) INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—Paragraph (2) of section 162(l) is amended by adding at the end the following new subparagraph:

"(C) INSURANCE MUST MEET CERTAIN STANDARDS.—Paragraph (1) shall apply only to insurance which is an accountable health plan or certified health plan (as defined in section 106).".

(C) TREATMENT OF MULTIEMPLOYER HEALTH PLANS.—Subsection (l) of section 162 is amended by adding at the end the following new paragraph:

"(6) TREATMENT OF MULTIEMPLOYER HEALTH PLANS.—For purposes of this subsection, an amount paid into a multiemployer health plan (as defined in section 91(d)(7) shall be deemed to be an amount paid for insurance which constitutes medical care.".

(c) EFFECTIVE DATE.—Except as provided in subsection (b)(1)(B), the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

TITLE III—FINANCING AND REFORMING FEDERAL PROGRAMS

Subtitle A—Medicare

SEC. 301. MEDICARE CHOICE.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended to read as follows:

"MEDICARE CHOICE

"SEC. 1876. (a) ESTABLISHMENT OF MEDICARE MARKET AREAS.—The Secretary shall establish various medicare market areas within the United States in such manner as to—

"(1) ensure that each individual entitled to benefits under part A and enrolled under part B, or enrolled under part B only, resides in a medicare market area;

"(2) maintain all portions of each metropolitan statistical area within one medicare market area; and

"(3) maximize the number of such individuals who will have the opportunity for a meaningful

choice among competing medicare health plans under contract with the Secretary under this section.

"(b) MEDICARE HEALTH PLANS.—

"(1) CONTRACTS WITH MEDICARE HEALTH PLANS.—The Secretary shall enter into a contract with any medicare health plan desiring to do business in a medicare market area and to receive payment under this section, but only if the Secretary certifies that such plan meets the requirements of paragraph (2).

"(2) CERTIFICATION REQUIREMENTS.—Each medicare health plan must—

"(A) be certified as an accountable health plan by the appropriate regulatory authority pursuant to title I of the Health Care Reform Act of 1994;

"(B) except as provided in paragraph (3), provide those services covered by this title (hereafter in this section referred to as 'medicare benefits') when medically necessary for a uniform monthly premium for a year;

"(C) not discriminate against beneficiaries based on their health status, claims experience, medical history, or other factors that are gen-

erally related with utilization of health care services;

"(D) demonstrate the ability to provide medicare benefits to all potential enrollees throughout the medicare market area, unless the Secretary determines it appropriate for such plan to provide services to a subset of such market area;

"(E) collect and provide such standard information as the Secretary shall prescribe by regulation as necessary to evaluate the performance and quality of such plan, including enrollee satisfaction, to compare such performance and quality with competing plans, and to prepare comparative materials for distribution to beneficiaries;

"(F) demonstrate the ability to integrate additional benefits into such plan for qualified medicare beneficiaries as provided in section 321 of the Health Care Reform Act of 1994; and

"(G) offer the supplementary coverage plans established by the Secretary under subsection (g)(3)(B).

"(3) COST SHARING.—

"(A) ACTUARIALLY EQUIVALENT MEDICARE BENEFITS.—Each medicare health plan must offer either—

"(i) medicare benefits, including the cost-sharing requirements otherwise provided in this title; or

"(ii) actuarially equivalent medicare benefits, as established by the Secretary in regulations, which are medicare benefits, but with cost-sharing requirements that are actuarially equivalent to the cost-sharing requirements otherwise provided in this title and consistent with common practices among health maintenance organizations and other managed care health plans.

In establishing actuarially equivalent medicare benefits, the Secretary shall not include in the calculation any change in costs associated with alternative forms of health care delivery, management, or utilization control.

"(B) OUT-OF-NETWORK COST SHARING.—Each medicare health plan may require enrollees to pay higher cost sharing for services than is otherwise required by this title (or required in the actuarially equivalent alternative) if—

"(i) the plan maintains a network of providers for all medicare benefits that would not require higher cost sharing; and

"(ii) the plan provides enrollees with such information.

"(4) CAPACITY LIMITS.—Each medicare health plan may apply to have limits placed on the number of beneficiaries that may enroll in the plan in an enrollment period if the plan can demonstrate—

"(A) that enrolling more than the limit would impair the plan's ability to provide services to other enrollees; and

"(B) enrollment in the plan is on a first-come first-served basis, except for individuals enrolled in the prior year.

"(c) EMPLOYER-SPONSORED HEALTH PLANS.—

"(1) CRITERIA FOR CERTIFICATION.—The Secretary shall prescribe, by regulation, criteria for certifying medicare health plans sponsored by employers which will be offered only to current or former employees, including requirements that such health plans—

"(A) are certified as accountable health plans pursuant to title I of the Health Care Reform Act of 1994;

"(B) provide benefits that cover at least those services covered by this title at a premium for the enrollee that does not exceed the base beneficiary premium (as defined pursuant to subsection (f)); and

"(C) are available to all eligible current and former employees in the medicare market area.

"(2) SECONDARY PAYER COVERAGE.—To be certified under paragraph (1), employer-sponsored health plans shall accept, at the option of individuals eligible only for secondary coverage under this title pursuant to section 1862(b), a fixed monthly payment from the Secretary to provide such individuals coverage at least actuarially equivalent to the secondary coverage available to such individuals under this title.

"(d) MANAGING MEDICARE CHOICE.—

"(1) MEDICARE HEALTH PLAN TOTAL MONTHLY PREMIUMS.—Before the beginning of each calendar year, each medicare health plan or employer-sponsored health plan under contract pursuant to subsection (b) or (c) shall submit to the Secretary the total monthly premium that such plan intends to charge in such year.

"(2) ANNUAL OPEN ENROLLMENT.—

"(A) IN GENERAL.—The Secretary shall provide for an annual open enrollment period during which all individuals entitled to benefits under part A and enrolled under part B, or enrolled under part B only, residing in a medicare market area—

"(i) shall choose enrollment for the next calendar year in—

"(I) a medicare health plan in such area,

"(II) an employer-sponsored health plan, or

"(III) coverage otherwise provided under this title (hereafter in this section referred to as 'medicare fee-for-service'); and

"(ii) may choose supplementary benefits offered by such health plan or a medicare supplemental policy (certified under section 1882).

"(B) SECONDARY PAYER.—Individuals who are eligible for secondary coverage under this title pursuant to section 1862(b), may not enroll in a medicare health plan but may enroll in

an employer-sponsored health plan, to which the Secretary shall make a monthly payment, pursuant to subsection (e)(2)(C).

"(C) PERIOD OF ENROLLMENT.—

"(i) IN GENERAL.—Except as provided in clauses (ii), (iii), and (iv), an individual may not choose another enrollment until the next annual period provided under subparagraph (A).

"(ii) ENROLLMENT UPON ELIGIBILITY.—The Secretary shall provide an enrollment period of 30 days to any individual beginning 30 days before the date such individual first becomes entitled to benefits under part A or enrolled under part B only. Such enrollment shall be effective on the date of such entitlement.

"(iii) TERMINATION OF PLAN.—If a contract for a medicare health plan under this section is terminated during any calendar year, the Secretary shall provide for an enrollment period of 30 days to any individual enrolled in such plan beginning on the date of such termination.

"(iv) INDIVIDUAL NO LONGER IN AREA.—An individual terminating residence in a medicare market area may terminate enrollment with the medicare health plan of such area as of the beginning of the first calendar month following the date on which the request is made for such termination, and the Secretary shall provide for an open enrollment period of 30 days to such individual for enrollment in the new medicare market area in which such individual resides beginning on the date of such termination. In the case of an individual's termination of enrollment, the medicare health plan shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the plan and may not receive medicare benefits other than through such plan.

"(v) EFFECTIVE DATE OF NEW ENROLLMENT.—Enrollment under clause (iii)

or (iv) shall be effective 30 days after the end of the enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

"(D) DEFAULT ENROLLMENT.—

"(i) IN GENERAL.—If an individual does not choose an enrollment option during an enrollment period under this paragraph, such individual shall be automatically enrolled in—

"(I) the same option into which such individual enrolled in the preceding enrollment period; or

"(II) if the individual was not enrolled in such preceding period, the medicare fee-for-service.

"(ii) NO MEDICARE HEALTH PLANS IN AREA.—If there are no medicare health plans in the medicare market area in which the individual resides, such individual shall be automatically enrolled in the medicare fee-for-service.

"(3) INFORMATION REGARDING MEDICARE OPTIONS IN MARKET AREA.—

"(A) IN GENERAL.—The Secretary shall provide each individual making an enrollment decision during any enrollment period described in paragraph (2) with the following information, in comparative form, regarding the medicare health plans and medicare fee-for-service available in the medicare market area in which such individual resides:

"(i) The individual's premiums for medicare benefits.

"(ii) The individual's premiums for any supplementary benefits.

"(iii) Enrollee restrictions.

"(iv) Quality information, including enrollee satisfaction and health outcomes.

"(v) Any other necessary information as determined by the Secretary.

"(B) MARKETING REQUIREMENTS.—The Secretary shall prescribe the procedures and conditions under which a medicare health plan that has entered into a contract with the Secretary under this section may inform individuals eligible to enroll under this section with the plan about the plan. No brochures, application forms, or other promotional or informational

material may be distributed by such plan to (or for the use of) individuals eligible to enroll with the plan under this section unless—

"(i) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review;

"(ii) the material is made available to all individuals eligible to enroll in the medicare health plan in the medicare market area; and

"(iii) the Secretary has not disapproved the distribution of the material.

The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(4) RISK ADJUSTMENTS.—

"(A) IN GENERAL.—The Secretary shall adjust the payments made to medicare health plans and employer-sponsored health plans under this title to reflect the relative health risks of classes of beneficiaries enrolled in such plans in the medicare market area. The Sec-

retary may define appropriate classes of beneficiaries, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence and the efficient delivery of health care. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

"(B) PENALTIES FOR DISCRIMINATION.—The Secretary shall have the authority to impose financial penalties on medicare health plans or employer-sponsored health plans that knowingly violate the prohibition against discrimination against potential enrollees based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services.

"(5) PAYMENTS TO PLANS.—

"(A) IN GENERAL.—The Secretary shall forward to each medicare health plan or employer-sponsored health plan the medicare per capita rate for the medicare market area, as determined under subsection (e), for every beneficiary enrolled in such plan for that month, ex-

cluding any beneficiary premium but reflecting any adjustments required pursuant to paragraph (4)(A).

"(B) COLLECTION OF BENEFICIARY PREMIUMS AND REBATES.—

"(i) PREMIUMS.—Each medicare health plan or employer-sponsored plan shall be responsible for collecting premiums owed by beneficiaries for enrolling in such plan, including premiums for medicare benefits and any supplementary benefits.

"(ii) REBATES.—Any medicare health plan or employer-sponsored plan which charges a total monthly premium which is less than the medicare per capita rate for an enrollee shall be responsible for paying to such enrollee a rebate equal to the excess medicare per capita rate or may use such rebate to offset any premium owed by the enrollee for any supplementary benefits selected by the enrollee.

"(C) SOURCE OF PAYMENT.—The amounts paid to medicare health plans and employer-sponsored health plans shall be made from the

Federal Hospital Insurance Trust Fund and the Supplementary Insurance Trust Fund based on an allocation determined by the Secretary.

"(e) MEDICARE PER CAPITA RATE.—

"(1) ANNOUNCEMENT.—With respect to each medicare market area, the Secretary shall announce, not later than October 1 (beginning with 1995) the per capita rate that will apply to such market area beginning with the enrollment year (which coincides with the next calendar year).

"(2) PER CAPITA RATE.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the per capita rate for a medicare market area shall be equal to the lesser of the maximum per capita rate or the sum of—

"(i) the excess of—

"(I) the benchmark premium for such area, over

"(II) the base beneficiary premium for such area; and

"(ii) the applicable percentage of the excess of—

"(I) the fee-for-service per capita costs (hereafter in this section referred to as 'FFSPCC') for such area, over

"(II) such benchmark premium.

For purposes of the preceding sentence, the applicable percentage shall be determined by the following table:

"Enrollment year:	Applicable percentage:
1996	90
1997	80
1998	70
1999	60
2000 and thereafter	50.

"(B) SECONDARY PAYER PER CAPITA RATE.—For individuals who are eligible for secondary coverage under this title pursuant to section 1862(b) and elect to enroll in an employer-sponsored health plan, the Secretary shall determine a per capita rate for each medicare market area equal to the costs of providing secondary coverage to all individuals in such market area divided by the number of individuals eligible for such coverage in such market area.

"(C) RURAL ENROLLEES.—

"(i) FIVE-YEAR BONUS.—For enrollment periods beginning in 1996 through

2000, the per capita rate in each medicare market area (otherwise determined under this paragraph) shall be increased by 10 percent (without regard to the maximum established under paragraph (3)) with respect to each individual enrolling in a medicare health plan or employer-sponsored health plan who resides in an underserved rural area within such market area, as determined by the Secretary.

"(ii) IMPROVE ACCESS.—The bonus amount paid under this subparagraph shall be used by such health plans to improve access and coordinated service delivery in the underserved rural area in which the enrollee resides. The bonus amount shall not reduce the premiums owed by the enrollee for medicare benefits or any supplementary coverage.

"(iii) STUDY AND RECOMMENDATIONS.—The Secretary shall report to the Congress at the end of the 5-year period described in clause (ii) on the status of health care access in underserved rural areas and shall make recommendations re-

garding continuation of bonus per capita payments.

"(3) MAXIMUM PER CAPITA RATE.—

"(A) IN GENERAL.—Except as provided in subparagraph (E), the maximum per capita rate in any medicare market area shall be the excess of—

"(i) the product of—

"(I) FFSPCC in all medicare market areas, and

"(II) an adjustment factor for such market area; over

"(ii) the fee-for-service beneficiary premium required pursuant to subsection (f)(2)(B)(ii).

"(B) ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(i)(II), and except as provided in subparagraph (D):

"(i) FFSPCC RATIO LESS THAN .8.—For medicare market areas with a FFSPCC ratio less than or equal to .8, the adjustment factor shall be .8.

"(ii) FFSPCC RATIO BETWEEN .8 AND .95.—For medicare market areas with a FFSPCC ratio less than .95 but greater

than .8, the adjustment factor shall be the sum of .85, plus—

"(I) .1, multiplied by

"(II) the ratio of the excess of the FFSPCC ratio over .8, to .15.

"(iii) FFSPCC RATIO BETWEEN .95 AND 1.05.—For medicare market areas with a FFSPCC ratio of at least .95 but less than 1.05, the adjustment factor shall be the FFSPCC ratio.

"(iv) FFSPCC RATIO BETWEEN 1.05 AND 1.2.—For medicare market areas with a FFSPCC ratio of at least 1.05 but less than 1.2, the adjustment factor shall be the sum of 1.05, plus—

"(I) .1, multiplied by

"(II) the ratio of the excess of the FFSPCC ratio over 1.05, to .15.

"(v) FFSPCC RATIO GREATER THAN 1.2.—For medicare market areas with a FFSPCC ratio greater than or equal to 1.2, the adjustment factor shall be 1.2.

"(C) FFSPCC RATIO.—For purposes of subparagraph (B), for each medicare market area, the Secretary shall determine a FFSPCC

ratio by dividing FFSPCC in such market area by FFSPCC for all medicare market areas.

"(D) BUDGET NEUTRALITY.—The Secretary shall change the adjustment factors as necessary to ensure that total spending under this title shall not exceed the level of spending that would occur if the maximum per capita rate in each medicare market area were equal to the FFSPCC in each such market area.

"(E) ALTERNATIVE FORMULA.—The Secretary may substitute an alternative formula for determining the maximum rate in each medicare market area. Such an alternative formula shall generally conform to the pattern of adjustment factors specified in subparagraph (B), except that such formula shall maintain a consistent mathematical relationship between the adjustment factor and the FFSPCC ratio in each such market area in a manner that achieves budget neutrality.

"(4) DEFINITIONS.—For purposes of this subsection:

"(A) BENCHMARK PREMIUM.—The benchmark premium for a medicare market area shall be equal to the sum of—

"(i) the lowest health plan total monthly premium submitted by a medicare health plan in such area for the enrollment year; and

"(ii) the applicable percentage of the excess of—

"(I) the average of all medicare health plan total monthly premiums submitted in such area, over

"(II) the lowest health plan total monthly premium in such area.

For purposes of the preceding sentence, the applicable percentage shall be determined by the following table:

"Enrollment year:	Applicable percentage:
1996	80
1997	60
1998	40
1999 and thereafter	20.

"(B) FEE-FOR-SERVICE PER CAPITA COSTS.—The Secretary shall determine FFSPCC for a medicare market area by dividing—

"(i) the total spending for medicare benefits (not including beneficiary cost sharing) for individuals who reside in such area, who are not enrolled in a medicare

health plan or employer-sponsored health plan, and who are not in secondary payer status; by

"(ii) the number of such individuals.

The Secretary shall make such other adjustments as may be necessary to allow an accurate comparison of FFSPCC for the medicare market area with total monthly premiums charged by medicare health plans in such area.

"(f) BENEFICIARY PREMIUMS.—For purposes of this section:

"(1) BASE BENEFICIARY PREMIUM.—The base beneficiary premium for each medicare market area shall be equal to the product of—

"(A) the ratio of the monthly premium determined under section 1839 to the national average cost per beneficiary under this title in 1995, as determined by the Secretary; and

"(B) the benchmark premium for such area.

"(2) MONTHLY BENEFICIARY PREMIUMS.—

"(A) HEALTH PLAN BENEFICIARY PREMIUM.—To be enrolled for coverage in a medicare health plan during an enrollment year for

medicare benefits, each beneficiary shall pay a monthly premium equal to the excess of—

"(i) the premium charged by the plan selected by the beneficiary; over

"(ii) the medicare per capita rate in the medicare market area in which the beneficiary resides.

"(B) FEE-FOR-SERVICE BENEFICIARY PREMIUM.—

"(i) IN GENERAL.—To be enrolled for coverage in a medicare fee-for-service in a medicare market area during an enrollment year for medicare benefits, each beneficiary shall pay a monthly premium equal to the estimated FFSPCC for the medicare market area, multiplied by the ratio determined under paragraph (1)(A).

"(g) SUPPLEMENTARY COVERAGE PLANS.—

"(1) IN GENERAL.—The Secretary shall ensure that all supplementary coverage plans meet the requirements of this subsection, in addition to any requirements that may be applicable under section 1882.

"(2) COORDINATION WITH MEDICARE CHOICE.—Supplementary coverage plans may only

be offered to beneficiaries during the same annual open enrollment period during which beneficiaries select medicare coverage and must be offered to all beneficiaries in the same medicare market area for the same, uniform monthly premium during the enrollment period.

"(3) STANDARD BENEFITS.—

"(A) IN GENERAL.—Medicare health plans may only offer standardized supplementary coverage plans, as established by the Secretary, after consultation with the National Association of Insurance Commissioners.

"(B) REQUIRED OPTIONS.—Among the standardized plans, the Secretary shall include a plan—

"(i) covering only outpatient prescription drugs; and

"(ii) which, together with medicare benefits, would resemble coverage typically offered by health maintenance organizations to employer groups, including an annual out-of-pocket maximum beneficiary liability (covering coinsurance, copayments, and deductibles).

"(4) ONE SPONSOR.—A sponsor of supplementary coverage may not offer such coverage to a beneficiary selecting a medicare health plan from a different sponsor, except that sponsors of supplementary coverage may offer such coverage to any individual selecting medicare fee-for-service.

"(5) SURCHARGE ON CERTAIN PLANS.—Notwithstanding any other provision of this section, if an individual chooses to purchase a medicare supplemental policy certified pursuant to section 1882 and the coverage under such policy results in increased costs to the program under this title, the monthly beneficiary premium otherwise applicable under this section shall be increased by a surcharge actuarially equivalent to such increased costs.

"(6) DEFINITIONS.—The term 'supplementary coverage plan' means any health insurance coverage offered by a medicare health plan or medicare supplemental policy (as defined in section 1882) that covers health care costs not covered as medicare benefits and for which the enrollee must pay a premium.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1882(c) of the Social Security Act (42 U.S.C. 1395ss(c)) is amended—

(A) by striking "with respect to paragraph (3)" and inserting "with respect to paragraphs (3) and (6)",

(B) by striking "and" at the end of paragraph (4),

(C) by striking the period at the end of paragraph (5) and inserting "; and", and

(D) by adding at the end the following new paragraph:

"(6) agrees—

"(A) to offer such policy during the annual open enrollment period specified in section 1876(c)(2) at a uniform monthly premium to all beneficiaries in a medicare market area established under section 1876(a); and

"(B) not to discriminate against beneficiaries based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services.".

(2) Section 1882(s) of such Act (42 U.S.C. 1395ss(s)) is amended—

(A) by striking paragraph (2),

(B) by striking "paragraphs (1) and (2)" in paragraph (3) and inserting "paragraph (1)", and

(C) by redesignating paragraph (3) as paragraph (2).

(3) Section 1839(e) of such Act (42 U.S.C. 1395r(e)) is amended to read as follows:

"(e) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month—

"(1) in 1994 shall be $41.10;

"(2) in 1995 shall be $46.10; and

"(3) after December 1995 shall be an amount equal to 25 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into with respect to calendar years beginning after December 31, 1995.

SEC. 302. OTHER MEDICARE PROVISIONS.

(a) APPLICATION OF COMPETITIVE ACQUISITION FOR FEE-FOR-SERVICE ITEMS AND SERVICES.—

(1) GENERAL RULE.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) is

amended by inserting after section 1846 the following:

"COMPETITIVE ACQUISITION FOR ITEMS AND SERVICES

"SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

"(1) IN GENERAL.—The Secretary shall, in each medicare market area, award a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1996.

"(2) ALTERNATIVE AREAS.—The Secretary may establish areas other than medicare market areas for competitive acquisition of an item or service described in subsection (c), if the establishment of such an area increases the availability and accessibility of suppliers and the probability and amount of savings to be realized by the use of such competitive acquisition in such area.

"(b) AWARDING OF CONTRACTS IN AREAS.—

"(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

"(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any indi-

vidual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity—

"(A) meets quality standards specified by the Secretary for the furnishing of such item or service; and

"(B) offers to furnish a total quantity of such item or service that is sufficient to meet the expected need within the competitive acquisition area.

"(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)—

"(A) the quantity of items and services the entity shall provide; and

"(B) such other terms and conditions as the Secretary may require.

"(c) SERVICES DESCRIBED.—The items and services to which the provisions of this section shall apply are as follows:

"(1) Magnetic resonance imaging tests and computerized axial tomography scans, including a

physician's interpretation of the results of such tests and scans.

"(2) Oxygen and oxygen equipment.

"(3) Clinical diagnostic laboratory tests.

"(4) Such other items and services for which the Secretary determines that the use of competitive acquisition under this section will be appropriate and cost-effective.".

(2) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) by striking "or" at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting "; or", and

(C) by inserting after paragraph (16) the following new paragraph:

"(17) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Sec-

retary finds that such expenses were incurred in a case of urgent need.".

(3) REDUCTION IN PAYMENT AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUCTION IN PAYMENTS.—Notwithstanding any other provision of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), if the establishment of competitive acquisition areas under section 1847 of such Act (as added by paragraph (1)) and the limitation of coverage for items and services under part B of such title (42 U.S.C. 1395j et seq.) to items and services furnished by providers with competitive acquisition contracts under such section does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to the item or service under such part B if the item or service had not been furnished through competitive acquisition under such section, the Secretary shall reduce the payment amount by such percentage as the Secretary determines necessary to result in such a reduction.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished under part B of title XVIII of the Social

Security Act (42 U.S.C. 1395j et seq.) on or after January 1, 1995.

(b) EXPANSION OF CENTERS OF EXCELLENCE.—

(1) IN GENERAL.—The Secretary shall use a competitive process to contract with centers of excellence for cataract surgery, coronary artery by-pass surgery, and such other services as the Secretary determines to be appropriate for individuals enrolled in medicare fee-for-service. Payment under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) will be made for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

(A) The center shall cover services provided in a medicare market area (established pursuant to section 1876(a) of the Social Security Act) for years beginning with fiscal year 1996.

(B) The amount of payment made by the Secretary to the center under title XVIII of the Social Security Act (42 U.S.C. et seq.) for services covered under the project shall be less than the aggregate amount of the payments that the Secretary would have made to the center for such services had the project not been in effect.

(C) The Secretary shall make payments to the center on such a basis for the following services furnished to individuals enrolled in medicare fee-for-service and entitled to benefits under such title:

(i) Facility, professional, and related services relating to cataract surgery.

(ii) Coronary artery by-pass surgery and related services.

(iii) Such other services as the Secretary and the center may agree to cover under the agreement.

(2) REBATE OF PORTION OF SAVINGS.—In the case of any services provided under a demonstration project conducted under paragraph (1), the Secretary shall make a payment to each individual to whom such services are furnished (at such time and in such manner as the Secretary may provide) in an amount equal to 10 percent of the amount by which—

(A) the amount of payment that would have been made by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to the center for such services if

the services had not been provided under the project, exceeds

(B) the amount of payment made by the Secretary under such title to the center for such services.

(c) MEDICARE SECONDARY PAYER CHANGES.—

(1) EXTENSION OF DATA MATCH.—

(A) Section 1862(b)(5)(C) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(B) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(2) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) of such Act (42 U.S.C. 1395y(b)(1)(B)(iii)), as amended by section 13561(b) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(A) in the heading, by striking "SUNSET" and inserting "EFFECTIVE DATE", and

(B) by striking ", and before October 1, 1998".

(3) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section

1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)), as amended by section 13561(c) of the Omnibus Budget Reconciliation Act of 1993, is amended in the second sentence by striking "and on or before October 1, 1998,".

(d) REDUCTION IN UPDATE FOR INPATIENT HOSPITAL SERVICES.—Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended by section 13501(a)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) in subclause (XII)—

(A) by striking "fiscal year 1997" and inserting "for each of the fiscal years 1997 through 2000", and

(B) by striking "0.5 percentage point" and inserting "2.0 percentage points"; and

(2) in subclause (XIII), by striking "fiscal year 1998" and inserting "fiscal year 2003".

(e) REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c * (((1+r)

to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring on or after—

"(I) May 1, 1986, and before October 1, 1995, 'c' is equal to 1.89, and

"(II) October 1, 1995, 'c' is equal to 0.74.".

(2) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) of such Act (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "of 1985" and inserting "of 1985, but not taking into account the amendments made by section 302(e)(1) of the Health Care Reform Act of 1994".

(f) ELIMINATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.—

(1) IN GENERAL.—Effective October 1, 1995, in making any payment to hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Secretary shall discontinue payments under title XVIII of such Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—(i) Subsection (c) of section 4008 of the Omnibus Budget Reconciliation Act of 1987 is repealed.

(ii) Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(I) in subsection (l)(5), by striking subparagraph (C), and

(II) in subsection (r), by striking paragraph (4).

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall take effect on October 1, 1995.

(g) EXTENSION OF FREEZE ON UPDATES TO ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES.—

(1) PAYMENTS BASED ON COST LIMITS.—Section 1888(a) of the Social Security Act (42 U.S.C. 1395yy(a)) is amended by striking "112 percent" each place it appears and inserting "100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(a)(1) of the Omnibus Budget Reconciliation Act of 1993)".

(2) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Section 1888(d)(2)(B) of such Act (42 U.S.C. 1395yy(d)(2)(B)) is amended by striking "105 percent" and inserting "100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(b) of the Omnibus Budget Reconciliation Act of 1993)".

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to cost reporting periods beginning on or after October 1, 1995.

(h) ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES.—

(1) USE OF CUMULATIVE PERFORMANCE STANDARD.—Section 1848(f)(2) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)) is amended—

(A) in subparagraph (A)—

(i) in the heading, by striking "IN GENERAL" and inserting "FISCAL YEARS 1991 THROUGH 1994.—",

(ii) in the matter preceding clause (i), by striking "a fiscal year (beginning with fiscal year 1991)" and inserting "fiscal years 1991, 1992, 1993, and 1994", and

(iii) in the matter following clause (iv), by striking "subparagraph (B)" and inserting "subparagraph (C)";

(B) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraphs (A) and (B)";

(C) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(D) by inserting after subparagraph (A) the following new subparagraph:

"(B) FISCAL YEARS BEGINNING WITH FISCAL YEAR 1995.—Unless Congress otherwise provides, the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year beginning with fiscal year 1995 shall be equal to the performance standard rate of increase determined under this paragraph for the previous fiscal year, increased by the product of—

"(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part

for portions of calendar years included in the fiscal year involved,

"(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the previous fiscal year) which are estimated to result from

changes in law or regulations affecting the percentage increase described in clause (i) and which is not taken into account in the percentage increase described in clause (i), minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).".

(2) TREATMENT OF DEFAULT UPDATE.—

(A) IN GENERAL.—Section 1848(d)(3)(B) of such Act (42 U.S.C. 1395w–4(d)(3)(B)) is amended—

(i) in clause (i)—

(I) in the heading, by striking "IN GENERAL" and inserting "1992 THROUGH 1996", and

(II) by striking "for a year" and inserting "for 1992, 1993, 1994, 1995, and 1996"; and

(ii) by adding after clause (ii) the following new clause:

"(iii) YEARS BEGINNING WITH 1997.—

"(I) IN GENERAL.—The update for a category of physicians' services for a year beginning with 1997 provided under subparagraph (A) shall be

increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for such category of physicians' services for such year was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for such year.

"(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the 'cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and multiplied by 100. In the previous sentence, the 'adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year.".

(B) CONFORMING AMENDMENT.—Section 1848(d)(3)(A)(i) of such Act (42 U.S.C.

1395w–4(d)(3)(A)(i)) is amended by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)".

(i) LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.—

(1) IN GENERAL.—

(A) LIMITATIONS DESCRIBED.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), as amended by section 302(a)(1), is amended by inserting after section 1848 the following new section:

"LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

"SEC. 1849. (a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to

the hospital for the following year under subsection (b)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

"(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

"(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

"(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

"(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hos-

pital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

"(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year; and

"(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services fur-

nished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

"(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

"(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's

service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

"(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

"(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under sub-

section (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician's service furnished by a member of a hospital's medical staff to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for payment for such service not later than 90 days after the last day of the year.

"(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year—

"(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under

subsection (c), including interest at an appropriate rate determined by the Secretary;

"(B) if the actual average per admission relative value for such hospital's medical staff during the year is less than 15 percentage points above the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians' services performed in such hospital (prior to the withhold), the difference between 15 percentage points and the actual number of percentage points that the staff exceeds the limit allowable average per admission relative value, including interest at an appropriate rate determined by the Secretary; and

"(C) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff by 15 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

"(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

"(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

"(e) DEFINITIONS.—In this section, the following definitions apply:

"(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

"(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

"(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

"(2) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

"(3) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).".

(B) CONFORMING AMENDMENTS.—(i) Section 1833(a)(1)(N) of such Act (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting "(subject to reduction under section 1849)" after "1848(a)(1)".

(ii) Section 1848(a)(1)(B) of such Act (42 U.S.C. 1395w–4(a)(1)(B)) is amended by striking "this subsection," and inserting "this subsection and section 1849,".

(2) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) of such Act (42 U.S.C. 1395w–4(g)(4)(A)(i)) is amended by striking "beneficiary," and inserting "beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1998.

(j) IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.—

(1) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) are each amended—

(A) by striking "(or 100 percent" and all that follows through "the first opinion))", and

(B) by striking "100 percent of such negotiated rate" and inserting "80 percent of such negotiated rate".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to tests furnished on or after January 1, 1995.

(k) REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.—

(1) REDUCTION IN UPDATE TO MAINTAIN FREEZE IN 1996.—Section 1861(v)(1)(L)(i) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(A) in subclause (II), by striking "or" at the end,

(B) in subclause (III), by striking "112 percent," and inserting "and before July 1, 1996, 112 percent, or", and

(C) by inserting after subclause (III) the following new subclause:

"(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),".

(2) BASING LIMITS IN SUBSEQUENT YEARS ON MEDIAN OF COSTS.—

(A) IN GENERAL.—Section 1861(v)(1)(L)(i) of such Act (U.S.C. 1395x(v)(1)(L)(i)), as amended by paragraph (1), is amended in the matter following subclause (IV) by striking "the mean" and inserting "the median".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to cost reporting periods beginning on or after July 1, 1997.

(l) IMPOSITION OF COPAYMENT FOR CERTAIN HOME HEALTH VISITS.—

(1) IN GENERAL.—

(A) PART A.—Section 1813(a) of the Social Security Act (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

"(5) The amount payable for home health services furnished to an individual under this part shall be reduced by a copayment amount equal to 10 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital.".

(B) PART B.—Section 1833(a)(2) of such Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (A), by striking "to home health services," and by striking the comma after "opinion)",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting "; and", and

(iv) by adding at the end the following new subparagraph:

"(F) with respect to home health services—

"(i) the lesser of —

"(I) the reasonable cost of such services, as determined under section 1861(v), or

"(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A),

"(ii) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2), or

"(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section,

less a copayment amount equal to 10 percent of the average of all per visit costs for home

health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital;".

(C) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) of such Act (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(i) by striking "deduction or coinsurance" and inserting "deduction, coinsurance, or copayment", and

(ii) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to home health services furnished on or after July 1, 1995.

(m) REDUCTION IN HOSPITAL OUTPATIENT SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 1833(a)(2)(B) of the Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended by striking "section 1886)—" and all that

follows and inserting the following: "section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such items and services in various geographic areas, except that for items and services furnished during cost reporting periods (or portions thereof) in years beginning with 1995, such amount shall be equal to 90 percent of the amount that would otherwise have been determined;".

(2) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1995, the Secretary shall establish the prospective payment system for hospital outpatient services necessary to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by paragraph (1)).

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after July 1, 1995.

SEC. 303. INCOME-TESTED MEDICARE PREMIUMS.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination

of tax liability) is amended by adding at the end the following new part:

"PART VIII—CERTAIN MEDICARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

"Sec. 59B. Recapture of certain medicare subsidies.

"SEC. 59B. RECAPTURE OF CERTAIN MEDICARE SUBSIDIES.

"(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the aggregate of the Medicare recapture amounts (if any) for months during such year that a premium is paid under section 1876 of the Social Security Act for the coverage of the individual under such title.

"(b) MEDICARE RECAPTURE AMOUNT FOR MONTH.—For purposes of this section, the Medicare recapture amount for any month is the amount equal to the excess of—

"(1) either—

"(A) the total monthly premium charged by the medicare health plan in which the individual was enrolled (as determined under section 1876(d)(1) of the Social Securty Act), or

"(B) the fee-for-service per capita costs (as defined in section 1876(e)(4)(B) of such Act) for individuals enrolled in medicare fee-for-service during the month in the medicare market area in which the individual was residing, over

"(2) the sum of—

"(A) the monthly beneficiary premium owed by the individual (as determined by section 1876(f)(2) of such Act), and

"(B) 50 percent of the benchmark premium in the medicare market area in which the individual was residing (as determined under section 1876(e)(4)(A) of such Act).

"(c) PHASE IN OF RECAPTURE AMOUNT.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $25,000, the recapture amount imposed by this section for such taxable year shall be an amount which bears the same ratio to the recapture amount which would (but for this subsection) be imposed by this section for such taxable year as such excess bears to $25,000.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $75,000,

"(B) $100,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married (as determined under section 7703) but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return—

"(A) the recapture amount under subsection (a) shall be the sum of the recapture amounts determined separately for each spouse, and

"(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

"(4) COORDINATION WITH OTHER PROVISIONS.—

"(A) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the recapture amount imposed by this section shall be treated as if it were a tax imposed by section 1.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax under section 55.

"(C) TREATED AS PAYMENT FOR MEDICAL INSURANCE.—The recapture amount imposed by this section shall be treated as an amount paid for insurance covering medical care, within the meaning of section 213(d).".

(b) TRANSFERS TO MEDICARE TRUST FUNDS.—

(1) IN GENERAL.—There are hereby appropriated to the Hospital Insurance and the Supplemental Medical Insurance Trust Funds amounts equivalent to the aggregate increase in liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the application of section 59B(a)(1) of such Code, as added by this section.

(2) TRANSFERS.—The amounts appropriated by paragraph (1) shall be transferred from time to time (but not less frequently than quarterly) from the general fund of the Treasury on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in paragraph (1), and shall be allocated between the Hospital Insurance and the Supplemental Medical Insurance Trust Funds according to a formula established by the Secretary of Health and Human Services. Any quarterly payment shall be made on the first day of such quarter and shall take into account the recapture amounts referred to in such section 59B(a)(1) for such quarter. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(c) REPORTING REQUIREMENTS.—

(1) Paragraph (1) of section 6050F(a) of the Internal Revenue Code of 1986 (relating to returns relating to social security benefits) is amended by striking "and" at the end of subparagraph (B) and by inserting after subparagraph (C) the following new subparagraph:

"(D) the number of months during the calendar year for which a premium was paid under section 1876 of the Social Security Act for the coverage of such individual under such part, and".

(2) Paragraph (2) of section 6050F(b) of such Code (relating to statements to be furnished with respect to whom information is required) is amended to read as follows:

"(2) the information required to be shown on such return with respect to such individual.".

(3) Subparagraph (A) of section 6050F(c)(1) of such Code (defining appropriate Federal official) is amended by inserting before the comma "and in the case of the information specified in subsection (a)(1)(D)".

(4) The heading for section 6050F of such Code is amended by inserting "**AND MEDICARE COVERAGE**" before the period.

(5) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting "and Medicare coverage" before the period.

(d) WAIVER OF CERTAIN ESTIMATED TAX PENALTIES.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating to failure to pay estimated income tax) for any period before April 16, 1997, with respect to any underpayment to the extent that such underpayment resulted from section 59B(a) of the Internal Revenue Code of 1986, as added by this section.

(e) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end thereof the following new item:

"Part VIII. Certain medicare subsidies received by high-income individuals.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to periods after December 31, 1995, in taxable years ending after such date.

SEC. 304. MEDICARE ADMINISTRATIVE SIMPLIFICATION.

(a) CONSOLIDATION OF PARTS A AND B.—By not later than October 1, 1995, the Secretary shall submit to

the Congress a proposal to consolidate entitlement for part A of the title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) and enrollment in part B of such title (42 U.S.C. 1395j et seq.) into eligibility or enrollment into the entire medicare program under such title. In preparing such a proposal, the Secretary shall consider phasing in such a consolidation, and shall ensure that no beneficiary shall pay higher premiums for coverage under such program than under such program as of the date of the enactment of this Act.

(b) CONSOLIDATION OF FEE-FOR-SERVICE ADMINISTRATION.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act), including medicare supplemental policies, over a 5-year period.

(2) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary may contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate. No medicare market area (established under section

1876(a) of the Social Security Act) may be subject to more than 1 entity.

(3) STREAMLINED PROCESSING SYSTEMS.—In carrying out this subsection, the Secretary may ensure—

(A) a streamlined, standardized, and paperless process for handling all fee-for-service claims, and

(B) that payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are made first by the medicare program and medicare supplemental policies before providers can bill beneficiaries for services using standardized forms.

(4) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (42 U.S.C. 1395h and 1395u) (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this subsection.

Subtitle B—Health Discount and Medicaid Reform

PART I—HEALTH DISCOUNT

SEC. 311. STATE HEALTH DISCOUNT PROGRAMS.

(a) IN GENERAL.—To be certified by the Secretary as meeting the requirements of this Act, each State shall include within the State health reform plan a State administered program, consistent with this subtitle and such other requirements as determined necessary by the Secretary and issued in regulations, under which eligible persons shall receive premium assistance (hereafter in this part referred to as "health discounts") for purchasing health care coverage from AHPs.

(b) CATEGORIES OF ELIGIBILITY.—Persons who otherwise meet the criteria for entitlement under this part shall be divided into the following categories of eligibility:

(1) Eligible individuals, as defined in section 1(c)(3).

(2) Eligible employees, as defined in section 1(c)(2).

(c) SWITCHING CATEGORIES OF ELIGIBILITY.—Individuals and employees who are determined to be in 1 category of eligibility under subsection (b) but whose circumstances change and cause such individuals and employees to fall within the other such category shall remain

in the category of eligibility in which such individuals and employees were originally placed until the next open enrollment period under section 312(a)(2).

SEC. 312. HEALTH DISCOUNT PROGRAM DESIGN.

(a) ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—A State health discount program shall allow each eligible individual who otherwise meets the requirements for entitlement under this part to select from among competing AHPs in the market area in which such individual resides based on the price and quality of the competing AHPs and to use the discount to which such individual is entitled only to offset the premium charged by the AHP for the benefits package selected by the individual.

(2) ANNUAL OPEN ENROLLMENT.—

(A) IN GENERAL.—A State health discount program shall provide for an annual open enrollment period during which each eligible individual shall choose enrollment in an AHP to which the health discount to which such individual is entitled shall be paid.

(B) ENROLLMENT UPON ELIGIBILITY.—Eligible individuals shall have an open enroll-

ment period upon becoming eligible for a health discount.

(C) PERIOD OF ENROLLMENT.—After selecting an AHP during an open enrollment period, an eligible individual may not choose another AHP to which a health discount may be paid until the next annual open enrollment period, except that—

(i) an eligible individual moving to a new market area in the State shall be provided with a new open enrollment period, and

(ii) an eligible individual in an AHP that is terminated from the health discount program shall be provided with a new open enrollment period.

(3) COMPARATIVE INFORMATION ON ENROLLMENT OPTIONS.—During an open enrollment period, a State health discount program shall provide to the individual such information as may be necessary to ensure such individual may compare the price and quality of the AHPs available in the market area, including—

(A) premiums by type of benefits package of the competing AHPs,

(B) any restrictions by AHPs on enrollees' selection or use of health care providers and services,

(C) quality information, including enrollee satisfaction and measures of health outcomes,

(D) appeal rights of enrollees, and

(E) any other necessary information, as determined by the Secretary.

(4) AHP BENEFITS AND PREMIUMS.—AHPs, other than AHPs offered by employers as self-insured plans under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), in order to be certified pursuant to section 112 of this Act, shall—

(A) agree to participate in the State health discount program and make available to eligible individuals—

(i) the standard benefits package, as determined by the Secretary pursuant to section 113(a),

(ii) the nominal cost-sharing benefits package, as determined by the Secretary pursuant to section 113(b), and

(iii) the alternative benefits package, as determined by the Secretary pursuant

to section 113(c), if required pursuant to section 313, and

(B) submit, for each benefits package for each enrollment period, a uniform monthly premium for all eligible individuals in the market area, allowing adjustments in such premium only for those factors provided in section 112(d).

(5) DISCOUNTS.—Each eligible individual who otherwise meets the criteria for entitlement under this part shall be entitled to a health discount, as determined under subsection (c).

(6) INDIVIDUAL PREMIUMS.—To enroll in an AHP, an eligible individual must pay a premium equal to the excess of—

(A) the premium charged by the AHP for the benefits package selected by the individual, over

(B) the discount to which the individual is entitled.

(7) PAYMENTS TO AHPS.—

(A) IN GENERAL.—A State health discount program shall collect premiums from eligible individuals and forward to AHPs such premiums

and health discounts to which such individuals are entitled.

(B) RISK ADJUSTMENT.—

(i) IN GENERAL.—A State health discount program shall adjust the health discounts paid to the AHPs to reflect the relative health risks of classes of eligible individuals choosing to enroll in such plans in a market area. The Secretary may define appropriate classes of eligible individuals, based on age, disability status, and such other factors as the Secretary determines to be appropriate.

(ii) PENALTIES FOR DISCRIMINATION.—A State health discount program shall have the authority to impose financial penalties on AHPs that knowingly violate the prohibition against discrimination against potential enrollees based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services.

(b) ELIGIBLE EMPLOYEES.—

(1) IN GENERAL.—An eligible employee who otherwise meets the criteria for entitlement under this part and is enrolled in an AHP in a market area in a State shall get a health discount which may only be used to reduce the employee's premium for enrolling in such AHP.

(2) DISCOUNTS.—Each eligible employee who otherwise meets the criteria for entitlement under this part shall be entitled to a health discount, as determined under subsection (c).

(3) PAYMENTS TO AHPS.—A State health discount program shall forward to AHPs such health discounts to which such eligible employees are entitled.

(c) DETERMINING DISCOUNTS.—

(1) BENCHMARK.—

(A) IN GENERAL.—Each calendar year, a State health discount program shall determine benchmark monthly premiums for the calendar year for each class of family enrollment within each category of eligibility and within each market area.

(B) AHP BENEFITS AND PREMIUMS.—For purposes of determining discounts, AHP premiums shall be—

(i) for poor eligible individuals, those AHP premiums submitted pursuant to subsection (a)(4)(ii),

(ii) for low income eligible individuals, those AHP premiums submitted pursuant to subsection (a)(4)(i), or, if required by section 313, subsection (a)(4)(iii),

(iii) for poor eligible employees, those AHP premiums charged for the nominal cost-sharing benefits package in the small group market pursuant to section 112(d), and

(iv) for low income eligible employees, those AHP premiums charged for the standard benefits package in the small group market pursuant to section 112(d), except that AHPs may be required to establish separate monthly premiums for the alternative benefits package pursuant to section 313.

(C) CALCULATION.—The benchmark monthly premium shall equal the sum of the lowest premium charged by an AHP for the applicable benefits package plus the applicable percentage of the excess of—

(i) the average of all monthly premiums charged by AHPs, over

(ii) the lowest premium charged by an AHP.

For purposes of the preceding sentence, the applicable percentage shall be determined by following table:

Year:	Applicable percentage:
1996	80
1997	60
1998	40
1999 and thereafter	20

(2) POOR ELIGIBLE INDIVIDUALS AND EMPLOYEES.—For poor eligible individuals and poor eligible employees, the amount of the discount shall be equal to the benchmark for each category of eligibility.

(3) LOW INCOME ELIGIBLE INDIVIDUALS AND EMPLOYEES.—For low income eligible individuals and low income eligible employees, the amount of the discount shall be equal to the benchmark for each category of eligibility multiplied by—

(A) 100 percent, reduced by

(B) each percentage point by which the eligible individual's or eligible employee's family adjusted total income exceeds 100 percent of the Federal poverty line.

(4) DEFINITIONS.—For purposes of this part:

(A) POOR ELIGIBLE INDIVIDUALS AND EMPLOYEES.—The terms "poor eligible individual" and "poor eligible employee" mean an eligible individual or eligible employee with family adjusted total income not in excess of 100 percent of the Federal poverty line.

(B) LOW INCOME ELIGIBLE INDIVIDUALS AND EMPLOYEES.—The terms "low income eligible individual" and "low income eligible employee" mean an eligible individual or eligible employee with family adjusted total income exceeding 100 percent but not 200 percent of the Federal poverty line.

(C) FAMILY ADJUSTED TOTAL INCOME.—

(i) IN GENERAL.—The term "family adjusted total income" means, with respect to an eligible individual or eligible employee, the sum of the modified total income for the individual or employee and all the other eligible family members.

(ii) MODIFIED FAMILY INCOME.—The term "modified family income" means the sum of—

(I) the adjusted gross income (as defined in section 62(a) of the Inter-

nal Revenue Code of 1986) of the taxpayer and family members for the taxable year determined without regard to sections 911, 931, and 933 of such Code, determined without the application of paragraphs (6) and (7) of section 62(a) of such Code and without the application of section 162(l) of such Code, plus

(II) the interest received or accrued by the taxpayer and family members during such taxable year which is exempt from income, plus

(III) the amount of social security benefits (described in section 86(d) of such Code) which is not includable in gross income of the taxpayer and family members under section 86 of such Code.

(D) FEDERAL POVERTY LINE.—The term "Federal poverty line" means the income official poverty line as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(d) APPLICATIONS FOR HEALTH DISCOUNTS.—

(1) IN GENERAL.—Any individual who seeks assistance under this part shall submit a written application to the State health discount program.

(2) BASIS FOR DETERMINATION.—Subject to annual enforcement under subsection (e), health discounts under this part shall be based on 4 times the family adjusted total income during the 3 months preceding the month in which the application is filed.

(3) FORM AND CONTENTS.—An application for assistance under this part shall be in a form and manner specified by the State health discount program and shall require—

(A) the provision of information necessary to make the determinations described in subsection (b), and

(B) with respect to eligible employees, the provision of information with respect to the AHP in which the employee is enrolled (or in the process of enrolling).

(4) VERIFICATION.—The State health discount program shall provide for verification, on a sample or other basis, of the information supplied in applications under this part.

(5) PENALTIES FOR INACCURATE INFORMATION.—

(A) UNDERSTATED INCOME.—A State health discount program shall require individuals who knowingly understate income reported in an application to pay interest on the excess health discounts paid on behalf of such individual, in addition to repayment of the health discount.

(B) MISREPRESENTATION.—A State health discount program shall require individuals who knowingly misrepresent material information in an application for health discounts under this part to pay $1000 or, if greater, 3 times the excess health discounts paid based on such material misrepresentations.

(e) ANNUAL ENFORCEMENT OF HEALTH DISCOUNT ENTITLEMENT.—

(1) ANNUAL INCOME STATEMENT.—An individual receiving health discounts under this part in any year shall file with the State health discount program, by not later than April 15 of the following year, a statement verifying total adjusted family income for the taxable year ending during the previous year. Such a statement shall provide information

necessary to determine the family adjusted total income during the year and the number of family members as of the last day of the year.

(2) USE OF INCOME TAX RETURNS.—The State health discount program shall provide a process under which the filing of a Federal income tax return shall constitute the filing of an income statement under paragraph (1).

(3) RECONCILIATION BASED ON ACTUAL ANNUAL INCOME.—

(A) IN GENERAL.—Based on the information reported in the statement filed under paragraph (1), the State health discount program shall compute the annual health discount that should have been paid on behalf of the eligible individual or employee.

(B) RECONCILIATION.—If the health discount computed is—

(i) greater than the health discount paid, the program shall provide for payment to the individual or employee an amount equal to the amount of the underpayment, or

(ii) less than the health discount paid, the program shall require the individual or

employee to repay the excess health discount.

(4) FAILURE TO FILE.—If an individual required to file an income statement under this subsection fails to file such a statement, the State health discount program shall disqualify such individual for health discounts after May 1 of such year. The program shall waive the application of this disqualification if there is established, to the satisfaction of the program, good cause for the failure to file the statement on a timely basis.

(5) PENALTIES.—Any individual providing false information in a statement under paragraph (1) is subject to criminal penalties to the same extent as such penalties may be imposed under section 1128B(a) of the Social Security Act (42 U.S.C. 1320a–7b(a)) with respect to an individual described in clause (ii) of such section.

(6) NOTICE.—A State health discount program shall provide for written notice each year of the requirement under paragraph (1) to all individuals to whom the requirement applies.

(7) TRANSMITTAL OF INFORMATION.—The Secretary of the Treasury shall transmit annually to the State such information relating to the adjusted total

income of individuals for the taxable year ending in the previous year as may be necessary to verify the reconciliation of health discounts under this subsection.

(f) SMALL GROUP PURCHASING POOLS.—A State may contract with small group purchasing pools to administer portions of the health discount program, as appropriate.

SEC. 313. FINANCING HEALTH DISCOUNTS.

(a) IN GENERAL.—Health discounts shall be financed with—

(1) available Federal spending,

(2) required State Medicaid maintenance of effort spending and State matching amounts, and

(3) optional State supplementation.

(b) AVAILABLE FEDERAL SPENDING.—

(1) IN GENERAL.—For purposes of subsection (a), Federal spending for health discounts in a fiscal year shall be limited to the excess of—

(A) the amount specified in paragraph (2), over

(B) the estimated Federal expenditures under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.) for such year.

(2) SPECIFIED AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for fiscal year—

(A) 1996, is $282,800,000,000,

(B) 1997, is $311,000,000,000,

(C) 1998, is $343,100,000,000,

(D) 1999, is $378,800,000,000,

(E) 2000, is $416,300,000,000,

(F) 2001, is $449,600,000,000,

(G) 2002, is $481,100,000,000,

(H) 2003, is $510,000,000,000,

(I) 2004, is $540,600,000,000, and

(J) 2005 and any succeeding fiscal year, is the specified amount under this paragraph for the previous fiscal year increased by the percentage increase in the Gross Domestic Product for the previous fiscal year.

(3) LOOK BACK PROCEDURE.—The Secretary shall reduce (or increase) the amount specified in paragraph (2) for any fiscal year (beginning with 1997) by the amount by which actual Federal expenditures for titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.) and Federal spending for health discounts for the preceding year are greater than (or less than) the amounts specified

in paragraph (2) for the preceding fiscal year (determined after the application of this paragraph).

(c) STATE SPENDING.—For purposes of subsection (a)—

(1) MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—For each calendar quarter beginning after December 31, 1995, a State shall make available for the health discount program administered by the State under this part an amount equal to one-quarter of the annual maintenance of effort amount for the State for the fiscal year in which such quarter occurs as determined under subparagraph (B).

(B) ANNUAL STATE MAINTENANCE OF EFFORT AMOUNT.—

(i) IN GENERAL.—Except as provided in subparagraph (C), the annual maintenance of effort amount for any fiscal year shall equal the base maintenance of effort amount determined pursuant to clause (ii), updated by the index in clause (iii) for such fiscal year.

(ii) BASE AMOUNT.—For each State, the base maintenance of effort amount shall be the amount of total State expendi-

tures during fiscal year 1994 under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for acute care services.

(iii) INDEX.—

(I) IN GENERAL.—The Director of the Office of Management and Budget shall determine the index by which the base amounts shall be updated for each fiscal year after fiscal year 1994 by determining the projected change from the preceding fiscal year in medicaid acute care spending (Federal and State) projected in the baseline in effect at the time of enactment of this Act.

(II) OUT YEARS.—For fiscal years after the last fiscal year in the baseline projections, the index shall reflect overall change from the preceding fiscal year in the Gross Domestic Product.

(iv) ACUTE CARE SERVICES.—For purposes of this subparagraph, the term "acute care services" means all of the care and services furnished under a State plan

under title XIX of the Social Security Act (42 U.S.C. 1936 et seq.) except the following:

(I) Nursing facility services (as defined in section 1905(f) of the Social Security Act (42 U.S.C. 1396d(f))).

(II) Intermediate care facility for the mentally retarded services (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(III) Personal care services (as described in section 1905(a)(24) of such Act (42 U.S.C. 1396d(a)(24))).

(IV) Private duty nursing services (as referred to in section 1905(a)(8) of such Act (42 U.S.C. 1396d(a)(8))).

(V) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915 of such Act (42 U.S.C. 1396n).

(VI) Home and community care furnished to functionally disabled el-

derly individuals under section 1929 of such Act (42 U.S.C. 1396t).

(VII) Community supported living arrangements services under section 1930 of such Act (42 U.S.C. 1396v).

(VIII) Case-management services (as described in section 1915(g)(2) of such Act (42 U.S.C. 1396n(g)(2))).

(IX) Home health care services (as referred to in section 1905(a)(7) of such Act (42 U.S.C. 1396d(a)(7))).

(X) Hospice care (as defined in section 1905(o) of such Act (42 U.S.C. 1396d(o))).

(C) EXCEPTION.—For fiscal years beginning in the first calendar year in which the annual health discount entitlement is the maximum allowable (pursuant to subsection (d)), the State maintenance of effort amount shall be the amount for the preceding fiscal year increased by the estimated overall growth in spending for health discounts in the State as determined by the Secretary.

(D) ADMINISTRATIVE EXPENSES.—A State health discount program shall allocate a sufficient portion of State maintenance of effort spending to finance State expenses for administering the program.

(2) STATE MATCHING AMOUNTS.—For each calendar quarter after December 31, 1995, each State shall be required to pay 10 percent of the excess of—

(A) the total costs of health discounts in a State in such quarter, over

(B) the amount equal to—

(i) the State maintenance of effort amount for such quarter, divided by

(ii) 1, minus the Federal medical assistance percentage for the State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for such fiscal year.

(3) OPTIONAL STATE SUPPLEMENTATION.—A State, using State funds, may provide health discounts in excess of the amount that eligible individuals and eligible employees would otherwise be entitled to pursuant to subsection (d) and to eligible individuals and eligible employees who would not otherwise be entitled to such discounts.

(d) DETERMINING ENTITLEMENT TO HEALTH DISCOUNTS.—

(1) IN GENERAL.—At the beginning of each fiscal year, the Secretary shall establish the level of entitlement to health discounts for the upcoming calendar year by setting—

(A) the maximum annual income allowed for each category of eligibility under which eligible individuals and eligible employees are entitled to health discounts, and

(B) the alternative benefits package used, if necessary, for calculating the benchmarks and health discounts for low income eligible individuals and low income eligible employees.

The Secretary shall set the level of entitlement for a fiscal year so that the estimated total Federal spending on health discounts does not exceed the available Federal spending amount for such fiscal year.

(2) STATE SPENDING.—In determining the annual level of entitlement, the Secretary shall include in the determination the State maintenance of effort spending and State matching amounts but not optional State supplementation.

(3) ORDER OF ENTITLEMENT.—

(A) POOR INDIVIDUALS AND EMPLOYEES.—

(i) IN GENERAL.—In any year, the Secretary shall first ensure that all poor eligible individuals and poor eligible employees are entitled to health discounts based on the nominal cost-sharing benefits package determined pursuant to section 113(b).

(ii) EXCESS SPENDING.—If the Secretary determines that such a level of entitlement would cause Federal spending to exceed available amounts, the Secretary shall reduce the maximum family adjusted total income allowed for entitlement to health discounts to such a level so as to eliminate any estimated excess spending.

(B) OUT-OF-POCKET MAXIMUM FOR LOW INCOME INDIVIDUALS AND EMPLOYEES.—

(i) IN GENERAL.—If, in any year, the Secretary determines that all poor eligible individuals and poor eligible employees may be entitled to health discounts based on the nominal cost-sharing benefits package, then the Secretary shall next ensure that all low income eligible individuals and

low income eligible employees are entitled to health discounts based on the alternative benefits package determined pursuant to section 113(c).

(ii) EXCESS SPENDING.—If the Secretary determines that providing entitlement to health discounts for low income eligible individuals and low income eligible employees based on the alternative benefits package would (together with spending on poor eligible individuals and poor eligible employees under subparagraph (B)) cause Federal spending to exceed available amounts, the Secretary may only set the maximum family adjusted total income allowed for entitlement to health discounts (based on the alternative benefits package) for such low income individuals and employees at such a level so as to eliminate any estimated excess spending.

(C) STANDARD BENEFITS PACKAGE FOR LOW INCOME INDIVIDUALS AND EMPLOYEES.—

(i) IN GENERAL.—If the Secretary determines that all eligible individuals and eligible employees described in subpara-

graphs (A)(i) and (B)(i) may be entitled to health discounts, then the Secretary shall ensure that low income eligible individuals and low income eligible employees are entitled to health discounts based on the standard benefits package determined pursuant to section 113(a).

(ii) EXCESS SPENDING.—If the Secretary determines that providing such a level of entitlement would cause Federal spending to exceed available amounts, the Secretary shall increase the value of the alternative benefits package above the value provided under section 113(c) but below the standard benefits package so as to eliminate any estimated excess spending.

(4) EXCEPTION FOR MEDICAID-ELIGIBLES.—For fiscal years 1996 through 2000, any individual who—

(A) would have been eligible for medicaid acute services based on eligibility standards on the date of the enactment of this Act, and

(B) is otherwise an eligible individual or eligible employee,

shall be considered to be a poor eligible individual or poor eligible employee for purposes of paragraph (3)(A) and shall be entitled to health discounts based on the nominal cost-sharing benefits package without regard to the limit in available Federal spending and prior to the entitlement of other individuals under such paragraph.

PART II—TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE SERVICES UNDER THE MEDICAID PROGRAM

SEC. 321. TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE SERVICES UNDER THE MEDICAID PROGRAM.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

"TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE SERVICES

"SEC. 1931. (a) IN GENERAL.—Except as provided in subsection (b), the authority provided by this title to furnish acute care services to any individual eligible for medical assistance under this title shall terminate on December 31, 1994.

"(b) EXCEPTION FOR QUALIFIED MEDICARE BENEFICIARIES.—

"(1) IN GENERAL.—Individuals entitled to benefits under section 1905(p) shall remain entitled to such benefits under State plans.

"(2) ADDITIONAL BENEFIT.—Each state plan shall include as a mandatory benefit under section 1905(p)(3) the payment of premiums for qualified medicare beneficiaries to medicare health plans as provided in section 1876.

"(c) REPORT ON CONFORMING CHANGES.—By not later than 90 days after the date of the enactment of the Health Care Reform Act of 1994 the Secretary shall submit to Congress a report on changes in laws that should be made in order to conform those laws to the termination of authority under this section.

"(d) ACUTE CARE SERVICES.—The term 'acute care services' means all of the care and services furnished under a State plan under this title, except the following:

"(1) Nursing facility services (as defined in section 1905(f)).

"(2) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

"(3) Personal care services (as described in section 1905(a)(24)).

"(4) Private duty nursing services (as referred to in section 1905(a)(8)).

"(5) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915).

"(6) Home and community care furnished to functionally disabled elderly individuals under section 1929.

"(7) Community supported living arrangements services under section 1930.

"(8) Case-management services (as described in section 1915(g)(2)).

"(9) Home health care services (as referred to in section 1905(a)(7)).

"(10) Hospice care (as defined in section 1905(o)).".

Subtitle C—Increase in Tax on Tobacco Products

SEC. 330. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 331. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended—

(1) by striking "$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)" in paragraph (1) and inserting "$30 per thousand", and

(2) by striking "$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)" in paragraph (2) and inserting "$63 per thousand".

(b) CIGARS.—Subsection (a) of section 5701 is amended—

(1) by striking "$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)" in paragraph (1) and inserting "$19.125 cents per thousand", and

(2) by striking "equal to" and all that follows in paragraph (2) and inserting "equal to 31.875 percent of the price for which sold but not more than $75 per thousand."

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended by striking "0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)" and inserting "1.875 cents".

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended by striking "1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)" and inserting "3.75 cents".

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 is amended—

(1) by striking "36 cents (30 cents on snuff removed during 1991 or 1992)" in paragraph (1) and inserting "$6.36", and

(2) by striking "12 cents (10 cents on chewing tobacco removed during 1991 or 1992)" in paragraph (2) and inserting "$6.12".

(f) PIPE TOBACCO.—Subsection (f) of section 5701 is amended by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "$6.675 cents".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after September 30, 1995.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States which are removed before October 1, 1995, and held on such date for

sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on October 1, 1995, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on October 1, 1995, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before December 31, 1995.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998; 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on October 1, 1995, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, and such term shall include articles first subject to the tax imposed by section 5701 of such Code by reason of the amendments made by this Act.

(B) SECRETARY.—The term "Secretary" means the Secretary of the Treasury.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by para-

graph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 332. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: "Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.".

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

"(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which

have been labeled or shipped for exportation under this chapter,

"(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

"(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States.".

(3) Subsection (a) of section 5761 is amended by striking "subsection (b)" and inserting "subsection (b) or (c)".

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking "The penalty imposed by subsection (b)" and inserting "The penalties imposed by subsections (b) and (c)".

(5)(A) Subpart F of chapter 52 is amended by adding at the end the following new section:

"SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

"(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d).

"(b) CROSS REFERENCE.—

"For penalty for the sale of cigarettes in the United States which are labeled for export, see section 5761(d).".

(B) The table of sections for subpart F of chapter 52 of such Code is amended by adding at the end the following new item:

"Sec. 5754. Restriction on importation of previously exported tobacco products.".

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), 5763(b) and 5763(c) are each amended by inserting "or importer" after "manufacturer".

(2) The heading of subsection (b) of section 5763 is amended by inserting "QUALIFIED IMPORTERS," after "MANUFACTURERS,".

(3) The heading for subchapter B of chapter 52 is amended by inserting "**and Importers**" after "**Manufacturers**".

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting "and importers" after "manufacturers".

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking "EMPLOYEE USE OR" in the heading, and

(B) by striking "for use or consumption by employees or" in the text.

(2) Subsection (e) of section 5723 is amended by striking "for use or consumption by their employees, or for experimental purposes" and inserting "for experimental purposes".

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking "and manufacturers may similarly remove such articles for use of the United States;".

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking "On each book or set of cigarette papers containing more than 25 papers," and inserting "On cigarette papers,".

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting "under section 5704" after "internal revenue bond".

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking "or" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or".

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after September 30, 1995.

SEC. 333. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax) is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

"(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United

States, there shall be imposed a tax of $6 per pound (and a proportionate tax at the like rate on all fractional parts of a pound).".

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

"(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes.".

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking "and pipe tobacco" and inserting "pipe tobacco, and roll-your-own tobacco".

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking "or pipe tobacco" and inserting "pipe tobacco, or roll-your-own tobacco", and

(B) by striking paragraph (1) and inserting the following new paragraph:

"(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own to-

bacco solely for his own personal consumption or use, and".

(3) The chapter heading for chapter 52 is amended to read as follows:

"CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES".

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

"CHAPTER 52. Tobacco products and cigarette papers and tubes.".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after September 30, 1995.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before October 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

TITLE IV—IMPROVING ACCESS IN RURAL AREAS

SEC. 401. COMMUNITY HEALTH CENTERS.

Section 330(g)(1)(A) of the Public Health Service Act (42 U.S.C. 254c(g)(1)(A)) is amended by striking "and such sums" and inserting "such sums" and by inserting before the period the following: ", $800,000,000 for fiscal year 1995, $960,000,000 for fiscal year 1996, $1,100,000,000 for fiscal year 1997, and $1,200,000,000 for fiscal year 1998".

SEC. 402. NATIONAL HEALTH SERVICE CORPS.

Section 338H(b)(1) of the Public Health Act (42 U.S.C. 254q(b)(1)) is amended by striking "and such sums" and inserting "such sums" and by inserting before the period the following: ", $96,000,000 for fiscal year 1995, $115,000,000 for fiscal year 1996, $138,000,000 for fiscal year 1997, and $160,000,000 for fiscal year 1998".

SEC. 403. TAX INCENTIVES FOR PRACTICE IN FRONTIER, RURAL, AND URBAN UNDERSERVED AREAS.

(a) REFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.—

(1) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 34 the following new section:

"SEC. 34A. PRIMARY HEALTH SERVICES PROVIDERS.

"(a) ALLOWANCE OF CREDIT.—In the case of a qualified primary health services provider, there is allowed as a credit against the tax imposed by this subtitle for any taxable year in a mandatory service period an amount equal to the product of—

"(1) the lesser of—

"(A) the number of months of such period occurring in such taxable year, or

"(B) 36 months, reduced by the number of months taken into account under this paragraph with respect to such provider for all preceding taxable years (whether or not in the same mandatory service period), multiplied by

"(2) $1,000 ($500 in the case of a qualified primary health services provider who is a physician assistant or a nurse practitioner).

"(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means any physician, physician assistant, or nurse practitioner who for any month during a mandatory service period is certified by the Bureau to be a primary health services provider who—

"(1) is providing primary health services—

"(A) full-time, and

"(B) to individuals at least 80 percent of whom reside in a health professional shortage area (as defined in subsection (d)(2)),

"(2) is not receiving during such year a scholarship under the National Health Service Corps Scholarship Program or a loan repayment under the National Health Service Corps Loan Repayment Program,

"(3) is not fulfilling service obligations under such Programs, and

"(4) has not defaulted on such obligations.

"(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BUREAU.—The term 'Bureau' means the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration of the United States Public Health Service.

"(2) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means—

"(A) a geographic area in which there are 6 or fewer individuals residing per square mile,

"(B) a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act),

"(C) an area which is determined by the Secretary of Health and Human Services as equivalent to an area described in subparagraph (A) and which is designated by the Bureau of the Census as not urbanized, or

"(D) a community that is certified as underserved by the Secretary for purposes of participation in the rural health clinic program under title XVIII of the Social Security Act.

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) or the Social Security Act.

"(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(5) PRIMARY HEALTH SERVICES PROVIDER.—The term 'primary health services provider' means a provider of primary health services (as defined in section 330(b)(1) of the Public Health Service Act).

"(e) RECAPTURE OF CREDIT.—

"(1) IN GENERAL.—If, during any taxable year, there is a recapture event, then the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

"(A) the applicable percentage, and

"(B) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

"(2) APPLICABLE RECAPTURE PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Months 61 and thereafter	0.

"(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

"(3) RECAPTURE EVENT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during any mandatory service period.

"(B) CESSATION OF DESIGNATION.—The cessation of the designation of any area as a rural health professional shortage area after the beginning of the mandatory service period for any taxpayer shall not constitute a recapture event.

"(C) SECRETARIAL WAIVER.—The Secretary may waive any recapture event caused by extraordinary circumstances.

"(4) NO CREDITS AGAINST TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of deter-

mining the amount of any credit under subpart A, B, or D of this part.".

(2) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 34 the following new item:

"Sec. 34A. Primary health services providers.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after the date of the enactment of this Act.

(b) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

"SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

"(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

"(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the Na-

tional Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.".

(2) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act (42 U.S.C. 254l–1(g)) is amended by striking "Federal, State, or local" and inserting "State or local".

(3) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 136 and inserting the following:

"Sec. 137. National Health Service Corps loan repayments.
"Sec. 138. Cross references to other Acts.".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments made under section 338B(g) of the Public Health Service Act (42 U.S.C. 254l–1(g)) after the date of the enactment of this Act.

SEC. 404. INCENTIVES FOR PRIMARY CARE RESIDENTS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395 ww(h)) is amended—

(1) by striking paragraph (2) and inserting the following new paragraph:

"(2) DETERMINATION OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine an approved FTE resident amount for each cost report-

ing period beginning after October 1, 1994, as follows:

"(A) DETERMINING NATIONAL AVERAGE SALARY PER FTE RESIDENT IN FISCAL YEAR 1992.—The Secretary shall determine the national average salary for fiscal year 1992 for a full-time-equivalent resident in an approved medical residency training program.

"(B) UPDATING TO A COST REPORTING PERIOD THAT BEGINS IN FISCAL YEAR 1995.—The Secretary shall update the amount determined under subparagraph (A) by the estimated percentage change in the Consumer Price Index from the midpoint of fiscal year 1992 to the midpoint of each cost reporting period that begins in fiscal year 1995.

"(C) UPDATING TO SUBSEQUENT COST REPORTING PERIODS.—For each subsequent cost reporting period, the Secretary shall update the amount determined under subparagraph (B) or this subparagraph for an immediately preceding cost reporting period by the estimated percentage change in the Consumer Price Index from the midpoint of that preceding period to the midpoint of that subsequent period, with appro-

priate adjustments to reflect previous under- or over-estimations in the estimated percentage change in that index.",

(2) in paragraph (3)(B)(i), by striking "hospital's", and

(3) in paragraph (4), by striking subparagraph (C) and inserting the following new subparagraph:

"(C) WEIGHTING FACTOR FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

"(i) that the weighting factor for a primary care (as defined by the Secretary) resident, or for an intern, is 2.2;

"(ii) that the weighting factor for a nonprimary care resident who is in the resident's initial residency period is 2.0; and

"(iii) that the weighting factor for a nonprimary care resident who is not in the resident's initial residency period is 1.2.

The Secretary shall make such adjustments as are necessary to the weighting factors to maintain aggregate payments under this section to

all hospitals at the same level that such payments would have been made under this section prior to enactment of the amendments made to this section by the Health Care Reform Act of 1994.".

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided by paragraph (2), the amendments made by this section shall apply to cost reporting periods beginning after October 1, 1994.

(2) SPECIAL RULE.—For a cost reporting period that falls partly in fiscal year 1994 and partly in fiscal year 1995, the provisions of section 1886(h), as in effect before the date of enactment of this Act, shall apply proportionally to that part of the cost reporting period that occurs before fiscal year 1995.

TITLE V—OTHER HEALTH CARE COST REDUCTION MEASURES

Subtitle A—Medical Liability Reform

SEC. 501. FEDERAL STANDARDS FOR STATE-BASED MEDICAL LIABILITY REFORM.

(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall develop and publish medi-

cal liability reform standards in accordance with this subtitle that States must meet in order to be certified under section 502.

(b) BINDING ALTERNATIVE DISPUTE RESOLUTION.—

(1) REQUIREMENTS.—The standards developed under subsection (a) shall require that a State—

(A) require all claims of medical injury arising in such State be resolved under binding dispute resolution systems that—

(i) provide timely and impartial decisions of liability and damage awards,

(ii) make determinations of liability and damage awards based on the best scientific learning and judgment of objective experts,

(iii) provide data and standardized information regarding evidence of medical injuries and the causes of such injuries to Federal and State agencies responsible for monitoring or disciplining health care providers, and

(iv) do not employ lay juries or similarly constituted lay decisionmaking bodies to make such determinations;

(B) require that the decisions made through the binding dispute resolution system be final and not subject to further review by any court, except that a party to a dispute may obtain review of such decision in any court of competent jurisdiction in the State wherein the decision was made if—

(i) the award under such decision was procured by corruption, fraud, or other undue means,

(ii) there was evident partiality or corruption on the part of the arbiter,

(iii) the arbiter was guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy, or of any misbehavior by which the rights of any party were prejudiced, or

(iv) the arbiter exceeded its powers or so imperfectly executed them that a final and definite award upon the claim was not made; and

(C) require that where an arbiters award is vacated pursuant to State provisions established

under subparagraph (B) that the court direct that the matter be reheard by another arbiter under the procedures prescribed by the State dispute resolution system.

(2) OPTIONS.—The standards developed under subsection (a) shall permit a State to—

(A) allow private entities to provide all or some of the dispute resolution services required by the State dispute resolution system, and

(B) allow alternative methods for determining liability and compensation for personal injuries other than provider negligence and assessments of damage awards.

(3) BINDING ARBITRATION.—In the standards developed under subsection (a), the Secretary shall outline a standard arbitration process that States could adopt to meet Federal criteria (so long as other elements of the State system meet the requirements of this section) and that includes the following:

(A) Decisionmaking by a 3-person arbitration panel with expertise in medical injury disputes chosen from a roster of qualified and independent arbitrators.

(B) A period to permit the discovery of evidence.

(C) The right to a hearing.

(D) The right to a decision not later than 6 months after the date on which the claim was filed.

(E) The right to a written decision.

(c) DAMAGES.—When a claim that is subject to resolution in accordance with State systems established under the standards developed under subsection (a) results in a finding of liability, States shall require that the damages awarded adhere to the following requirements:

(1) Awards for noneconomic damages shall not exceed $250,000.

(2) Awards shall be reduced for any collateral source payments to which the patient is entitled for the medical injury for which the claim was filed.

(3) In the case of an award in excess of $100,000, claimants shall accept periodic payment of the amount of such awards that are intended to compensate the claimant for damages expected to be incurred in the future such as lost income and medical expenses.

(4) An award of punitive damages shall not be paid to the claimant, but shall be paid to the State

if the State has submitted a plan to the Secretary, and the Secretary has certified such a plan as part of certifying the State medical liability reform in accordance with section 502, to use such funds to improve the monitoring, disciplining, and educating of health care providers in the State to ensure they meet standards of competency.

(d) ACCOUNTABLE HEALTH PLANS.—

(1) IN GENERAL.—To be approved by the applicable regulatory authority as an AHP under section 112, a health plan shall clearly identify for the purchasers of the plan the individuals or entity that will be responsible for any findings of liability for claims of medical injury.

(2) ENFORCEMENT OF CONTRACTS.—A State shall ensure that provisions in AHP contracts that—

(A) cite medical practice guidelines, certified pursuant to section 502, and which shall be followed in rendering services, shall be deemed to supply the standard of care to be employed in determining liability under the State dispute resolution system, and

(B) establish particular rules governing the resolution of medical injury claims, consistent with the State dispute resolution system, are re-

quired elements for resolving any claims of medical injury for care provided in accordance with the AHP.

SEC. 502. CERTIFICATION.

(a) STATE REFORMS.—Not later than 12 months after the date of enactment of this Act, the Secretary, in consultation with the Attorney General, shall promulgate regulations that establish the criteria and procedures by which the Secretary (or individuals to whom the Secretary has delegated such authority) will determine whether or not a State has met the standards established under section 501(a) and any other standards determined necessary by the Secretary.

(b) STANDARDS FOR IMPOSING LIABILITY.—Not later than 12 months after the date of enactment of this Act, the Secretary shall promulgate regulations that establish the criteria to be used for the certification of medical practice guidelines by the Secretary (or individuals to whom the Secretary has delegated such authority), including criteria to ensure that such guidelines—

(1) reflect up-to-date scientific learning and the judgment of objective experts,

(2) are supported by proper documentation, and

(3) are accompanied by justifications for the standards established.

(c) OTHER REGULATIONS.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate other regulations necessary to carry out this Act.

SEC. 503. RELATION TO OTHER LAWS.

The procedures required under this Act for fairly and quickly resolving claims against health care providers for personal injury shall be exclusive, and no action seeking recovery for any personal injury covered by this Act shall be permitted in any Federal or State court except as expressly provided herein.

Subtitle B—Antitrust Provisions

SEC. 511. PUBLICATION OF GUIDELINES FOR ACCOUNTABLE HEALTH PLANS.

(a) IN GENERAL.—The President shall provide for the development and publication of explicit guidelines on the application of antitrust laws to AHPs. The guidelines shall be designed to facilitate AHP development and operation, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which an AHP (or organization that proposes to establish an AHP) may obtain a prompt opinion from the Department of Justice on the AHP's conformity with the antitrust laws. If the Department of Justice determines that an AHP conforms with

the antitrust laws, the AHP shall not be liable under such laws regarding the development and operation of the AHP, as reviewed by the Department.

(c) ANTITRUST LAWS DEFINED.—In this section, the term "antitrust laws" has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition.

SEC. 512. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary, shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative effort that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such collaborative effort, and the parties to such effort, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in

by such effort if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care collaborative effort if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the effort outweigh the reduction in competition (if any) that is likely to result from the effort, and

(B) such reduction in competition is reasonably necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the collaborative effort is likely—

(i) to maintain or to increase the quality of health care,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers,

such as economies of scale, reduced transaction costs, and reduced administrative costs,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or are likely to be) affected by the health care collaborative effort and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care collaborative effort on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the effort.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care collaborative effort (in the case of an effort in existence as of the time of the application) and implementation plan for the collaborative effort.

(d) ELIGIBLE HEALTH CARE COLLABORATIVE EFFORT.—To be an eligible health care collaborative effort for purposes of this section, a health care collaborative effort shall submit to the Attorney General an application

that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the effort that the effort will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the effort,

(2) an agreement that the effort will submit to the Attorney General annually a report that describes the operations of the effort and information regarding the impact of the effort on health care and on competition in health care, and

(3) an agreement that the parties to the effort will notify the Attorney General and the Secretary of the termination of the effort not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care collaborative effort submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certifi-

cate, the Attorney General shall be deemed to have issued such certificate.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care collaborative effort with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—

(i) IN GENERAL.—If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care collaborative effort involved may commence a civil action, not later than 60 days after receiving notice of the denial or rev-

ocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) CERTIFIED COPY OF RECORD.—As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative effort involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care collaborative effort with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term "antitrust laws"—

(A) has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) The term "certificate" means a certificate of public advantage authorized to be issued under subsection (a).

(3) The term "health care collaborative effort" means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision of health care services and that in-

volves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(4) The term "health care services" includes services related to the delivery or administration of health care services.

(5) The term "liable" means liable for any civil or criminal violation of the antitrust laws.

(6) The term "provider of health care services" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

Subtitle C—Administrative Cost Savings

SEC. 521. ESTABLISHMENT OF STANDARDS.

(a) IN GENERAL.—The Secretary shall establish, after consultation with the American National Standards Institute, data and transaction standards, conventions, and requirements that permit the electronic interchange of any health care data the Secretary determines nec-

essary for the efficient and effective administration of the health care system.

(b) TIMETABLE AND COVERAGE.—The Secretary shall establish standards, conventions, and requirements for categories of health care data in the following order and at the appropriate time (as determined by the Secretary):

(1) Financial and administrative transactions, including enrollment, eligibility, claims, and claims status.

(2) Quality measurement indicators, including such data necessary to satisfy the requirements under section 521.

(3) Patient care records.

(c) PRIVACY AND CONFIDENTIALITY STANDARDS.—In developing the standards, conventions, and requirements under subsection (a), the Secretary shall ensure the protection of privacy of participants in the health care system and ensure the confidentiality in the data interchange system.

SEC. 522. ENFORCEMENT.

(a) AHPS.—An AHP may not be certified by the appropriate regulatory authority unless such AHP complies with the standards established by the Secretary under section 521.

(b) HEALTH CARE PROVIDERS.—AHPs may only contract with or employ those health care providers that comply with the electronic standards established by the Secretary or submit standard paper forms with the same data elements to a clearinghouse which forwards the data electronically to AHPs.

Calendar No. 427

103D CONGRESS
2D SESSION

S. 2096

AN ACT

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, and for other purposes.

MAY 16, 1994

Read the second time and placed on the calendar